FY 1992 BUDGET FOR VETERANS BENEFITS AND SERVICES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

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FY 1992 BUDGET FOR VETERANS BENEFITS AND SERVICES

WEDNESDAY, FEBRUARY 20, 1991

House of Representatives,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to notice, at 9 am., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery, (chairman of the committee) presiding.

Present: Representatives Mr. Edwards of California, (vice chairman) Mr. Applegate, Mr. Evans, Mr. Penny, Mr. Staggers, Dr. Rowland, Mr. Slattery, Mr. Harris, Mr. Kennedy, Mrs. Patterson, Mr. Sangmeister, Mr. Jones, Dr. Long, Mr. Peterson, Mr. Edwards of Texas, Ms. Waters, Mr. Brewster, Mr. Pickett, Mr. Geren, Mr. Stump, Mr. Hamerschmidt, Mr. Smith, Mr. Bilirakis, Mr. James, Mr. Stearns, Mr. Spence, Mr. Nichols and Mr. Santorum.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The Chairman. The committee will be in order.

We have been told that the other committee chairmen like our idea of starting on time and they have adopted our rule or precedent, or whatever you call it. We do have some effect in the Congress.

Mr. Secretary, we are pleased to have you and your colleagues before the committee this morning to discuss the Administration's 1992 budget request for our Nation's veterans.

As we meet today, many of our thoughts are on the events in the Persian Gulf. We know that America's finest men and women are serving over there. I think all Americans understand they are doing the job the President and the Congress have decided that needs to be done. The entire Nation stands behind them. But as much as we support our young men and women in the Middle East, let us not forget the needs of the current veterans who must rely on the VA for many benefits and services. I understand that problem and situation.

In this committee, support for our troops means more than speaking proudly of them, and the bookcases in the rear of the room document how this committee met the Nation's obligation to returning veterans of past wars. We have tried.

History teaches us that the United States was never fully prepared for the aftermath of war. For instance, at the end of World War II, the veterans hospital system really was not ready to meet the needs of all the wounded. During the Vietnam War, we were able to save the lives of many seriously wounded soldiers. But the VA was forced to care for them in overflowing wards.

Many of us can also remember a breakdown in our educational benefits system in the early 1970's when veterans waited months for overdue checks. If there is one thing we can do for the men and women serving in the Gulf, it is to do everything in our power to prevent similar situations from happening again.

Mr. Secretary, your written testimony points out many of the positive things included in the budget proposal. We also know that you asked for a lot more than what is in the budget, almost $500 million more for existing medical programs. You asked for $250 million more for hospital construction, $47 million more for research, around $40 million more for the Veterans Benefits Administration, and $11 million more for cemeteries.

If the budget has included those amounts, we could do something about the 4,000 hospital beds that are closed due to funding shortages. We could do something about the brown grass and sunken gravesites in our national cemeteries. National cemeteries are supposed to be national shrines. Sadly many of them today are not maintained at the high standard they should be. This budget will not correct the current situation—the deficiencies.

Mr. Secretary, that is bad, when we cannot take care of our dead and keep our cemeteries to the best. Now, we all know that the American Battle Monument Commission, does a super job and we sure need to keep our cemeteries up to that standard.

With the dollars you requested, we could do something about the endless wait for benefits and services from the Veterans Benefits Regional Offices. This budget will do very little, if anything, to enhance the ability to adjudicate claims more quickly.

We could start to do something about outdated equipment and rundown buildings at our medical centers and clinics. Unfortunately, the construction budget will not provide the funds to do so.

Overall, the Administration's budget projects that spending for all domestic discretionary programs will increase by over 6 percent. The spending for discretionary VA programs will increase by 4.6 percent. Although I have never questioned your commitment to our veterans, Mr. Secretary, it is clear that our veterans are not at the top of OMB's priority list.

There are significant increases proposed for the Pell Grant and for other higher education assistance programs. Yet, Mr. Secretary, there has been no increase in the GI Bill rates for veterans in the last 5 years. I am disappointed that you, Mr. Secretary, did not even request an increase in the basic GI bill benefits when Pell grants were increased by $2 billion. We have got kids over there, men and women fighting over in the Persian Gulf and you did not even make a request for an increase in educational benefits. You know, if you do not ask for it, you are certainly not going to get it.

The Administration Budget also includes a large increase for research and development. But this increase does not include VA research.

Although there are problems at some of our medical centers, I believe the large majority provide the best care anywhere. The problem for some veterans is getting the care when and where they need it.

Mr. Secretary, despite the apparent increase in the medical care account, it is doubtful that this budget will allow medical centers to deliver the same care they delivered last year and are delivering now. The budget adds new programs, but they are funded at the expense of existing programs. I know the members should be very careful that when we add new programs we certainly need to find the money, because it does put a load on the Veterans Department.

Now, there is no funding for recently discovered drug price increases. When you look closely, employment levels for the Veterans Benefit Regional Offices and for the national cemeteries are going down, they are not going up.

Finally, Mr. Secretary, and I will get off your back. I want to express my disappointment that disabled veterans will not receive the 5.4 percent COLA until they receive their April checks. Now, veterans are getting the wrong message when it takes almost 2 months to get an increase in the benefits out to them. Of course, Congress should have sent the President a COLA bill last year. That was our fault, but we know where the problem was. But Speaker Foley and the Senate Majority Leader made it clear that the veterans COLA bill would be the first bill enacted when we convened in January. That was adequate time to run the tape so that Treasury could include the increase in the March checks.

Now, Mr. Secretary, really, there is no excuse for the COLA not being in the March checks. I kept saying on the floor, as well as Mr. Stump, Mr. Applegate, and Mr. McEwen, we are going to see that it gets in the March checks. It did not happen, now it is April.

You know, you have over 40 employees working in your Legislative Congressional staff. You've got more employees down there in that department than we have up here in the whole veterans' staff. It looks like they would have been watching the television, or somebody would have told us, then we would not have been embarrassed. So, I know you will look into this matter and won't let it happen again.

I'd like to recognize Mr. Stump.

OPENING STATEMENT OF HON. BOB STUMP

Mr. Stump. Thank you, Mr. Chairman. I'd like to also welcome the Secretary with us this morning and Tony Principi, the Deputy Secretary, as well as Dr. Holsinger and General Gray and the rest of you from the Veterans Affairs Department.

I know we have a mark-up in Armed Services, Mr. Chairman, and I'd like to ask unanimous consent that my complete remarks be made a part of the record. I'll just be very brief.

Secretary Derwinski and his team should be commended for their efforts to obtain the resources needed to begin revitalizing the VA. Unfortunately, though, the final numbers are all too familiar for our Nation's veterans.

Congress and the Administration need to progress well beyond the current service budgets for the VA. I certainly echo your expression of support for the VA, Mr. Chairman. We'll work with you and our committee members to make improvements where we can.

Thank you.

The Chairman. Mr. Secretary.

OPENING STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Secretary **Derwinski**. Thank you, Mr. Chairman. I would ask that my complete statement be placed in the record.

The **Chairman**. Without objection, so ordered.

Secretary **Derwinski**. I'll be relatively brief.

We have a number of new members here I see this morning, so, I'd like to identify the members of my team here. On my far left is Jo Ann Webb, who's the Director of our National Cemetery System; Dr. Jim Holsinger, who is our Chief Medical Director; and you all know Tony Principi, Deputy Secretary; D'Wayne Gray, the Chief Benefits Director; and Tony McCann, who is our Assistant Secretary for Finance and Planning; and also behind me here, Bob Coy is the Deputy General Counsel and Mark Catlett is the Deputy Assistant Secretary for Budget. Where's Mark?

The **Chairman**. Tell them to hold up their hands.

Secretary **Derwinski**. We hope we will be able to answer a good many of your questions this morning.

At the risk of sounding slightly undiplomatic, Mr. Chairman, it seems to me you've got your mind made up on a number of things and I am not going to debate or argue with you, unless you really want to take the gloves off. We will do that at the right time, if you wish. But, I would like to run through my testimony just very briefly.

The **Chairman**. All we want you to do is answer our questions. We do not care how you do it.

Secretary **Derwinski**. Okay. Good then. I would be especially happy to go over the COLA issue with you and be sure that you understand what happened rather than be upset about it.

But we have, as you know, very tight constrictions in the new reconciliation process and, in view of the caps under the Deficit Reduction Act and the uncertainty of how that entire ball game is being played out, we think that our budget increase of almost $1 billion for VA health care is a fair achievement. In fact, in the last 2 years, the increases, including two supplementals, have added $3 billion to the medical care account. I think that speaks for itself as far as our effort to serve veterans.

The concern that you have expressed and hundreds of members have expressed over the question of the impact of Desert Storm on future VA procedures is something we're painfully aware of. Dr. Holsinger has worked the last 6 months almost and major attention has been focused on the responsibilities we have under the law.

We are hoping and praying that there will be a minimum of casualties that come to the VA system, but we are ready in the event they do come.

We would also like to point out that we appreciate the committee's action early this year in processing individual pieces of legislation that were bogged down in the closing days of the fiscal year 1990 session of Congress. We had worked hard at the time to produce an agreement between the House and the Senate and, as you know, everything seemed to fall through. But at least a good many corrective steps have been taken early in this particular session.

Then I would like to point out that we have approached the VA the last 2 years with what I consider a very realistic set of standards, concentrated on our older veterans. There is no denying the fact that our veterans are getting older, especially World War II veterans. They are the largest single group of our users. We have been moving more and more toward long-term health care.

For example, last year 2,200 more beds were added in long-term health care facilities, and that includes those provided through state grants as well as direct VA adjustment.

This year, in the budget for fiscal year 1992, we hope to add another 1,900 nursing home beds. There's no doubt that that is where the emphasis will have to be in the future.

Also, we've made many changes. Without meaning to automatically inflate their egos, I think I could tell you that Dr. Holsinger and D'Wayne Gray have both brought tremendous new leadership and vitality to their assignments. We think we're a better institution today than we were 2 years ago.

Tony Principi has made it a special point to tackle some very difficult subjects; for example, the Sandoz Drug Company, in an effort to work them into line so they wouldn't be picking the pocket of the Federal Government and the VA. Tony also has been a father, if I may use that term, of the proposal before you.

He standardized DIC, the Dependency and Indemnity Compensation payment, to make it more equitable. That's a proposal we're very serious about. I commend Tony for carrying the ball on that very important initiative.

Overall, we think that, given the complexity of the veterans' world, and the challenge we're going to have with the new veterans coming aboard from Desert Storm, the VA will marshall its resources as effectively as we can. We understand our limitations; we're not a perfect institution, but we're the only VA there is. We better be as good as we can be.

In the last 2 years, we've tried to face reality and the reality is that we inherited a somewhat antiquated, dust-covered system. We've tried to shake it up and we've made innovations. We've challenged the sacred cow status of individual hospital directors, of leadership in our medical field.

We've asked questions. We've demanded to know why things aren't getting done and we've had a fairly exciting 2 years running the VA. We think our veterans are better served because of that. We also think, by the way, that the current crisis in the Persian Gulf has totally revitalized the spirit of most of our employees in anticipation of the responsibility they're going to face and the service they're going to render and I think they're going to be up to the task.

So, with that, I will stop at this point and we're all ready to answer any questions you and the rest of the panel may have.

[The prepared statement of Secretary Derwinski appears on p. 109.]

The CHAIRMAN. Thank you, Mr. Secretary. We're not questioning that you hadn't assembled a good team. I'm very, very impressed with the team you have. It's one of the best I've seen.

But when we see problems, we're going to point them out to you. What you ought to do, as a good soldier; you ought to correct those problems and march on. Don Edwards will operate under the 5-minute rule.

Mr. EDWARDS OF CALIFORNIA. Thank you, Mr. Chairman. I subscribe to your opening statement which I thought was excellent and, of course, I welcome the Secretary who is an old friend of all of us. We appreciate what he's trying to do.

Mr. Secretary, regarding the Palo Alto Medical Center that was so severely damaged in the Loma Prieta earthquake, are you up to date on the reconstruction of that facility? It is a very important VA facility.

Secretary DERWINSKI. Yes, Tony will respond to you, Mr. Edwards.

Mr. PRINCIPI. Yes, Mr. Edwards, we certainly are on top of the Palo Alto facility and we're moving ahead expeditiously towards a replacement of that structure. In fiscal year 1992, we will begin the site work and have the steel erected for the new tower.

Things are on track. We've made a commitment to replacement and it will be done.

Mr. EDWARDS OF CALIFORNIA. We're concerned in our office about the adjudication of claims at the VA. We understand that it's taking more time for the DVA to work these claims and that the quality of the work is going down. We also hear that there is a tremendous turnover in the adjudication staff; 50 percent or more in some urban areas.

Yet, in your budget, you don't support any improvement. What is your response to our worrying about the adjudication?

Secretary DERWINSKI. General Gray will give you the details, but we did try to improve our staffing in our negotiations with OMB and what we went into is, I guess, what one would politely call the realities of the Washington budget situation. We were far more successful for our request for funds in the medical field than we were in the benefits and cemetery divisions. I will yield to General Gray.

General GRAY. With regard to the last part of your question, sir, I don't know what office you are talking about, but I will be glad to check into it and provide answers, if needed. With regard to overall timeliness and quality, we're in just about a hold-your-own mode with this budget.

Actually, our timeliness has improved, but it's a very small improvement. It's parts of a percentage point. The quality, to my reading and my understanding of the adjudication process, is not the same as yours. It is not declining.

As a matter of fact, it is improving as more and more of our recently hired adjudicators get more experienced and get on the job full-time. I share what I sense is your frustration at the fact that our timeliness is not getting significantly better, but as the Secretary said, we didn't find it possible to gain the help we needed this year in order to move in that direction.

Mr. EDWARDS OF CALIFORNIA. Well, General, your statistics show that your error rate is going up rather dramatically, and I trust that you will take a look at that.

General **Gray**. I shall, sir. I don't know the statistics you're talking about. I'll get that from the staff.

[The information follows:]

During fiscal year 1990 our regional offices in Buffalo, NY; Jackson, MS; and Muskogee, OK had more than 50 percent trainees in their Adjudication Divisions. As of December 31, 1990, our New York Regional Office was also included in that category with 25 out of 45 adjudicators being classified as trainees.

Previous statistics on error rates were compiled from regional office reviews and were comprised of substantive, material and procedural errors for both rating and authorization actions. That method is being replaced by error rate statistics based only on Central Office review and comprised of payment or service errors, regardless of the source. These two methods of maintaining error rates are not directly comparable, and we are discontinuing that former in favor of the latter which we believe to be a more accurate assessment of our benefit delivery system.

Under the previous method based on regional office reviews, our error rates were as follows:

	1989	1990
Rating		
Substantive Errors	1.92 %	1.94 %
Material Errors	2.28 %	2.46 %
Procedural Errors	3.80 %	3.62 %
Authorization		
Substantive Errors	2.98 %	3.35 %
Material Errors	3.72 %	3.57 %
Procedural Errors	6.65 %	6.13 %

Our new error rate statistics show payment errors of 2.6 percent and service errors of 6.2 percent.

Mr. **Edwards of California**. We'll show it to you. The last question Mr. Chairman, has to do with—and I think all of the members of the committee are concerned about this—getting our veterans to the hospitals. The budget imposes restrictions on eligibility for beneficiary travel to these facilities. Many won't be able to get there.

When they live miles from a hospital or a clinic, it is a real problem.

Dr. **Holsinger**. Congressman, the beneficiary travel account is reduced for 1992 based upon establishing a 50-mile radius. Any beneficiary within a 50-mile radius would not receive beneficiary travel funding to come to the hospital.

About 83 percent of our patients live within that 50-mile radius. The 50-mile decision is, in a sense, arbitrary, but it is based upon the large number of our patients that do live within that radius.

Outside of 50 miles, of course, we will pay beneficiary travel funding to service-connected veterans with more than 50 percent service connection, as well as indigent individuals.

It was a hard decision to make, but there are higher-priority medical programs than the beneficiary travel account.

I think one of the most important things to note is that there are 176 DAV vans that are currently available for transporting veterans to our facilities and an additional 40 have been ordered.

We will soon have 216 DAV vans which will be available and that means virtually every one of our facilities will have at least one van and many will have two, that will help to provide transportation for those living within 50 miles that do not have the resources to come to the hospital.

Mr. **Edwards of California**. Thank you.

Thank you, Mr. Chairman.

The **Chairman**. Bob Stump.

Mr. **Stump**. Thank you.

General Gray, let me follow up on what you were speaking of a minute ago.

What initiatives are being taken, actually? Are there specific initiatives to establish more modern procedures to enhance this quality and timeliness of the claims?

General **Gray**. The chief initiative is, the modernization of our data-handling equipment, and this year, Mr. Stump, there is a big lump proposed for a stage-one purchase of modernization equipment.

You know, what we do, really, is handle information in my side of the VA. Dr. Holsinger and Ms. Webb have different problems. We take information from veterans, match it against a set of standards that the law and regulation prescribe, but our product is a check drawn on the Treasury.

So, the ability to acquire, manipulate, and to disseminate information is really what we are about, and we are embarked on a major modernization of our capability to do that both accurately and rapidly. That is the chief initiative, and it was fully funded.

We are also improving the training of adjudicators, who are the guts of our claims-processing organization. The Adjudication Academy, which the Congress funded 2 years ago, is in process, going well, and receiving good marks from those who attend and who send students.

Those are the chief initiatives, Mr. Stump, that I would mention in answer to your question.

Mr. **Stump**. What percentage of those adjudicators are trainees?

General **Gray**. Do you mean adjudicators that are in the field now?

Mr. **Stump**. Yes.

General **Gray**. I do not have a precise answer, sir—let me get that back to you—but larger than I would wish, larger than you would wish.

Mr. **Stump**. Thank you.

General **Gray**. Yes, sir.

[The information follows:]

As of December 31, 1990, our records showed that 35 percent of all adjudicators were trainees.

Mr. **Stump**. Thank you, Mr. Chairman.

The **Chairman**. Without objection, members have statements, and these statements will be put in the record, and I will call the members' names. Some of them have left, but the record will show that they were here.

Doug Applegate, chairman of compensation subcommittee.

STATEMENT OF HON. DOUGLAS APPLEGATE

Mr. **Applegate**. Thank you, Mr. Chairman.

First of all, Mr. Secretary, it is good to have you back, good to see you before the committee again, good to have a chance to work with you, and we have, and we have had a good relationship.

I agree with the chairman that you have assembled an excellent staff. You have been a very good soldier and, in fact, a leader in the House of Representatives, so you know how the system works, and we are hopeful that we will be able to work together to cure some of the ills that we see, to bring about the most equitable system that we can, not that we do not have one now, because I believe we do, but we can always make it better.

In the Persian Gulf situation, as we see, some of these young people that will be coming back—I have a lot of people say—I think there has been over 100 pieces of legislation that have been introduced into the Congress.

Everybody is rushing in with all of this, for one reason, I suppose, to look good; another reason, to try to help these soldiers, and we do have the system here, and it is ready. The programs are ready to accept them and to help them in every possible way.

I will say that I think that Representative Jim Jontz, who was a member of this committee, had a good suggestion, and that is in post-traumatic stress and the development, maybe, of some halfway houses for these new people that are coming back.

Now, whether they get into battle or whether they do not—and God help us if they do, and I hope they do not, but just sitting out there, there has been stress and strain and terrible pressures on them, and a lot of them are going to need this immediately, and I hope that there are these counseling centers, these programs that will be available to help them on their immediate return.

The chairman, of course, is the head of the Hospital and Health Care Subcommittee, and we can see where there has been a severe reduction in health services to the tune of somewhere around a billion or a billion and a quarter dollars over the past 10 years, services that have been drastically cut to the degree that I do not believe that the veterans, when they go into the hospitals, are getting everything that they ought to be getting, and that while we may be saying that we are going to pump more money into it, most of it has been eaten up by inflation, and so, if we stick another billion dollars in, we are not going to get the full use of the billion in order to bring back all of the services that are necessary to bring it up to the qualitative level that we really feel that we ought to have, and I think it is going to be very important that we do that, but I am also concerned, too, having said that, Mr. Secretary, that the proper attention, I don't believe, has been paid to the staffing levels in the VBA, and I wanted to address that, particularly in the adjudication activities.

Now, I have some questions here, but I am going to be able to finish off a little bit of the statement and maybe get a question in, and then I am going to submit them and have your people answer them, but in addition to a continued lack of timeliness in claims processing, the quality of decisions is suffering even more, I believe, and I would say, reiterating the concerns that Don Edwards was expressing, the error rates particularly in substantive errors do continue to grow, and then, even to make matters worse, there is not even a hint of what steps the Administration would be prepared to take if the system suddenly becomes inundated with this large amount of claims that would be resulting from the Persian Gulf War.

Mr. Secretary, I wanted to touch quickly on the renewed proposal that we index future COLAs in the compensation and DIC programs.

The Administration is projecting a COLA of 5.2 percent will be needed to offset the eroding effects of inflation, apparently.

I doubt as to whether this would be in the best interest, and I am talking about indexing, to the disabled veterans and service-connected older survivors.

Certainly, we do not want to see what happened in the last session. We want to make sure that if there is any other attached legislation it does not get stuck and get caught up in any controversy.

However, my inclination is to continue with the annual legislation, however, we'll see how everybody feels about that. It looks like that's only the warning light.

Let me get a chance to slip in a question here. You did propose 30 additional full-time employees for the Compensation and Pension Programs above your current estimate of 4,226. What is the actual level of today and what level of FTEE do you expect to reach in 1991 and do you think that there will be any progress made in the timeliness and quality statistics?

Secretary Derwinski. General?

General Gray. I don't have the numbers that you asked for, Mr. Applegate. I'll put those into the record. We do not expect fiscal year 1992 to see any significant improvement in the timeliness or quality. As we've said, we're in a hold-your-own mode with this budget the way it is.

We did ask for more people. The Secretary wanted us to have more people. We did not get them. We hope that with the modernization of our ADP, better training, and as trainees mature in their jobs in the future, it will get better, but it won't be this year, sir.

[The information follows:]

> At present, the actual level of FTEE is 3,891. Our authorized ceiling for fiscal year 1991 was increased to 4,226. We anticipate that we will have 4,226 personnel on board by the end of the fiscal year.

Mr. Principi. I would just like to add, with regard to Desert Storm, Mr. Applegate, we have requested an additional $12 million from the Administration so that we can bring on more employees as well as ADP support so that we can provide those people—get those people trained now because when those troops return, we do know there will be an increased workload as a result of Desert Storm, whether it be education claims, comp or whatever it might be.

We are in the process of doing that now, trying to get a supplemental or deficiency allocation to move money forward. Also, with regard to the timeliness issue, I think it's important to note that we did receive the $42 million for the ADP modernization. That's the first of 3 years to modernize all of our ADP equipment, so that will help our timeliness and our quality.

We also received legislation from the Department of Defense and the Armed Services Committee that they are required to provide us with the military records, the medical record of military personnel for compensation claims for disabled veterans. In the past, that could take 90 or 120 days to get those medical records from the Department of Defense and that impacts on our quality and the timeliness of adjudicating those claims. It's just not the VA, it's the Department of Defense that's involved in this as well.

Mr. APPLEGATE. Thank you very much for those answers.

The CHAIRMAN. Before recognizing Mr. Spence—and we're going by the way you came in here—I'd like to make a couple of comments. I talked to the Secretary last night. As I understand it, Mr. Secretary, you didn't make a request or there is no request from the Veterans Department in this Supplemental that guides the Armed Services Committee.

They've got a list that long in the Supplemental for personnel, doctors and everything you can imagine. What's going to happen to our system?

Secretary DERWINSKI. Mr. Chairman, we are keeping a running, open tab of all of the expenses we're incurring and we've been negotiating with OMB for inclusion in the supplemental. It's my understanding that the first supplemental will be entirely an in-theater funding of the DOD operations and that we would, in subsequent supplementals, presumably receive our necessary expenses.

In the meantime, of course, if there is a flow of casualties to VA hospitals, those troops will be coming in as servicepersons. As a result, the budgetary costs will be borne by the DOD. So, the immediate impact won't be an immediate budget problem for us.

The CHAIRMAN. Mr. Secretary, I'm watching it very closely because the Armed Services Committee really submitted some things that overlap as far as the veterans are concerned and I want to be sure that the best way to get the funding for this Persian Gulf operation is certainly through a Supplemental.

Secretary DERWINSKI. We're in touch daily with OMB. Frankly, if I have to spend——

The CHAIRMAN. That might be the problem.

[Laughter.]

Secretary DERWINSKI. Well, unless you're going to abolish them——

The CHAIRMAN. They've been in touch with me and Bob Stump.

Secretary DERWINSKI. That will be fine with us, but there they are. They're a necessary entity and we do business with them.

The CHAIRMAN. Before recognizing Mr. Spence, we have another panel here, but I want the members to see who these people are because they might want to call on them, and some members have to leave. If Tom Collins will just stand up? He's the Assistant Secretary of Labor for Veterans Affairs.

[No response.]

The CHAIRMAN. Well, he left. That took care of him.

[Laughter.]

The CHAIRMAN. We have two judges with the U.S. Veterans Court of Appeals, Judge Kenneth Kramer and Judge John Farley. Will you stand up at this point so we can see who these gentlemen are? They will testify, but some members will be gone. You've served up here and you know the problems of these committees.

Mr. Hammerschmidt has left. Mr. Spence is a new member of the committee, but distinguished member of the Congress from South Carolina.

Mr. SPENCE. Thank you, Mr. Chairman, Mr. Secretary and gentlemen and ladies. It's a pleasure to have you here. I'm new on the committee. This is my first year, first Full Committee meeting.

I'm not going to have a whole lot to say right now, but I am interested, Mr. Secretary, in your plan for abolishing OMB.

[Laughter.]

Mr. SPENCE. I'll sign up right away for that and then we'll go on from there. Seriously, in your summary, you have proposed a payment form plan for doctors and nurses. Could someone elaborate a little bit more on that?

Secretary DERWINSKI. You've passed the bill in the House and it's being worked on at the Senate Veterans' Affairs Committee level. We hope to have that package agreed upon soon and to have the Senate—the Senate will presumably act with dispatch.

Mr. SPENCE. I hope so; it's needed. That's all I have, Mr. Chairman.

The CHAIRMAN. Thank you, Floyd. We have a bill today again in Veterans' Affairs. You have a bill on the floor that pertains to the Veterans Court of Appeals.

Next is Harley Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman. Mr. Secretary, normally when I'm out in my district, I give you high praises because I think you do a good job. I do appreciate the staff you have; I work very well with them.

One thing that you mentioned earlier, I can't let pass. You mentioned that there is a billion dollar increase and that shows your commitment to veterans. That reduces veterans to dollars and cents. I would have one response and I guess it's a two-word response and the first word would be "bull"; the second word, I'd let you guess, but I would give you a hint: it's a substance that usually is lumpy and stinks.

I think that is basically what I would say about looking at it, putting it in dollars and cents, and not looking at the veterans.

The more I looked at your budget, I looked at it last year and looked at this year, and it seems like I am the one, at least my subcommittee takes the brunt of some of your proposals. With the loan guarantee, you propose a 2.5 percent fee, and a 10-percent downpayment, then you come to the conclusion that you will have a $59 million increase because of the additional fees. Since veterans would find it cheaper to go to a conventional loan, how can you say that there would be an increase? In fact, I would guess there would probably be a decrease.

I guess my question would be this. Will veterans not be less likely to use the program, and therefore, will the program not lose money?

Secretary DERWINSKI. No, not really, because for veterans, it still, from a practical standpoint, gives them an edge over FHA and conventional financing.

But, General, you have statistics, do you not?

General GRAY. I do not have statistics. The point you make, Mr. Staggers, is valid, to this extent, that there will probably be some—

you are talking about the second use of veterans. There will be some who will find alternative lenders, and, in that case, we will not get their loans. Neither will we have their defaults. Neither will we have the percentage of loss. The program operates in a deficit. The loan guarantee program overall costs the taxpayer money.

Mr. STAGGERS. Well, if I could interrupt, when we have given additional personnel for the servicing of those loans, is it not a fact that we have reduced the defaults?

General GRAY. We have, sir. We have not eliminated them, but we have reduced them.

Mr. STAGGERS. I guess we basically just disagree on this. I feel very strongly that I do not want to leave it to chance that there will be an increase. We are looking at money that is very precious in the Federal budget, especially within this program. It seems to me that we should not take that chance and have more hurdles for the veterans to go through.

General GRAY. I cannot think of a way, sir, I cannot follow your logic to the point of where we lose money. I can follow your logic to the point where we do not put as much money into the fund as otherwise would be the case. But in increasing, if you will, the net deficit, increasing the loss, I cannot get there on this. But I understand where you are coming from, Mr. Staggers.

Mr. STAGGERS. I think we basically just disagree.

General GRAY. Yes, sir.

Mr. STAGGERS. The second question I would have is with the cemeteries. There is an increase, and I appreciate that. I realize how tough it is to come up with increases.

But with the increase, I do not think we should be dancing in the streets. It is my understanding that, even with the increase, you will have to cut employees. Are you undermanned? You cannot purchase necessary equipment to maintain the cemeteries. We will not be able to adequately water our cemeteries?

I have read where you are in favor of expanding into the Chicago area, which I commend you for, and I think that that is something that we should look at. But I also understand we do not even have enough money to open up the new cemetery in Northern California.

It just seems to me that there are some inconsistencies. Should we be talking about expanding when we do not have adequate money to maintain, number one, and even open the new cemetery in Northern California.

Secretary DERWINSKI. Ms. Webb would give you the details. Let me get back to your original comment. As I understood you, you were discussing the point of not equating veterans with money, and we do not.

Mr. STAGGERS. I thought that is what I heard you say. I thought you said that we have a billion-dollar increase, and that shows our commitment to veterans.

Secretary DERWINSKI. That is right; it does. Because we have to fight for it.

Mr. STAGGERS. This may be an indication. But I do not think you can reduce the commitment to veterans to whether we have an increased dollar amount, especially, as I said, with cemeteries, there is an increase, but it does not necessarily cover our shortfalls which we have had in the past.

Now, you mentioned that you inherited some problems, but as the chairman says, that is all of our problem, and we cannot just throw up our hands and say we cannot do anything.

Secretary DERWINSKI. It seems to me the key is to do the best we can with what we have.

Mr. STAGGERS. But we need to be honest. As I said, we should not be proposing building a new cemetery in Chicago when we cannot even open the one in Northern California. We should not be saying to the veterans that we have a commitment for housing when we are going to increase the fee and have a down payment requirement.

Secretary DERWINSKI. The reason we are focusing in Chicago, there are a million veterans in the Northern Illinois area. Milwaukee's cemetery is about to close. The nearest cemetery is 300 miles away, and anybody who looks at the numbers in the area, realizes that they should have priority.

Mr. STAGGERS. Can I ask unanimous consent to ask one additional question?

Ms. Webb, if you were to reply for the record, because I have a very good working relationship with you, and I trust that I will get some good information. But if I could ask one more parochial question.

You mentioned, you responded to the chairman that there is adequate money for health care. Is there going to be adequate money for health care in West Virginia? That is one of my primary concerns also.

Secretary DERWINSKI. Yes. There is plenty of money for West Virginia.

Mr. STAGGERS. So when I go back to my veterans, I can say I have talked to you and you have given me the assurance?

Secretary DERWINSKI. No, I told you there is plenty of money in West Virginia. I wish there was as equitable a distribution of money in the other 49 States as there is in West Virginia.

To be very honest with you, Mr. Staggers, I would much prefer if any members of this panel would rise above parochialism and focus on our national picture.

Mr. STAGGERS. I am focusing on the veterans that live in West Virginia.

Secretary DERWINSKI. I am focusing on the veterans in all 50 States. There is a little difference there.

Mr. STAGGERS. Is there going to be adequate funding for health care for my veterans in my state?

Secretary DERWINSKI. Your veterans in proportion to veterans in most other States are doing very well.

Mr. STAGGERS. Is that a yes or a no?

Secretary DERWINSKI. I say your veterans, in proportion, in comparison to veterans in most other States, are doing very well.

Mr. STAGGERS. Is he answering my question? I do not think he is.

The CHAIRMAN. He is asking if you can get enough money, as I understand, for the West Virginia VA Hospital. Is your answer yes?

Secretary DERWINSKI. I thought I answered that. I said——

Mr. **STAGGERS**. "In proportion." Is that a yes?

Secretary **DERWINSKI**. All right. You are getting more than your fair share per capita in West Virginia.

Mr. **STAGGERS**. Once again we are going back to dollars and cents. Are we going to have adequate health care? Yes or no?

Secretary **DERWINSKI**. You are getting more than adequate medical care in West Virginia, because the resources allocated to West Virginia proportionately make you and your Senate delegation look very good.

Mr. **STAGGERS**. Thank you.

The **CHAIRMAN**. I wish we had a Byrd in each one of our States.

[Laughter.]

The **CHAIRMAN**. Is this mike on? A little slow out there.

[Laughter.]

The **CHAIRMAN**. Yes. Dick Nichols from Kansas, new member.

Mr. **NICHOLS**. Thank you very much.

The **CHAIRMAN**. It pays to get here.

Mr. **NICHOLS**. It does pay to get here. Thank you very much.

This last week, I had the privilege of touring two veterans medical centers in Kansas, and, of course, the emphasis there is on what is going to happen with Desert Storm and the casualties coming from there, Mr. Chairman; I saw increasing concern about the plight of World War II veterans and Vietnam veterans who were suffering flashbacks, or, I believe as Mr. Applegate or Mr. Edwards mentioned, post-traumatic stress disorders. Many of these veterans, who had been well-rehabilitated from their wartime experiences, were checking back in, and they were suffering some problems mentally and needing some care.

I wondered if the Secretary would elaborate a little bit on the emphasis that this budget would place on that.

Secretary **DERWINSKI**. First, remember the 1992 budget is not a Desert Storm budget. The 1992 budget is taking into account the long-term needs of the VA.

We will cover the problems of all sorts arising from Desert Storm as we face them, but in the area of PTSD, we have a great amount of expertise of necessity, the national leaders, and Dr. Blank, who runs that program, has been especially energetic the last 3 or 4 months in addressing just the point that you have raised, which is the recurring problems this would cause with some of the Vietnam Veterans.

Dr. Holsinger has worked with Dr. Blank on that, and I would like to yield to him at this point.

Dr. **HOLSINGER**. Mr. Nichols, it is of interest that—specifically, to deal with this year, when we may have the most impact from Desert Storm as far as previous veterans are concerned, we are in the process of opening a series of new units across the country.

We have already opened a new specialized inpatient PTSD unit at Lyons this year, and that has completely erased their backlog in that area. We have another seven yet to open that are in process across the country. We also have 8 new PTSD clinical teams, and they're coming online this year, and 13 new outpatient programs in our hospitals.

In addition, we have been able to accomplish it this year due to the $5 million PTSD add-on that occurred in the appropriations bill last fall, so that we have, fortuitously, a series of new units and new teams coming online at a time when we are seeing some increased difficulty among prior war veterans during this period of conflict.

Mr. PRINCIPI. Mr. Nichols, I might add, on the vet center program, which was designed for Vietnam-era veterans, we have submitted legislation to expand eligibility for that program to post-Vietnam-era, veterans of Grenada, Panama, and now the Persian Gulf, so they will be eligible, and that legislation has been submitted to the Hill.

Mr. NICHOLS. Thank you very much, because it does appear a bit unusual, I guess, that even some people who were well over those problems, now due to the tremendous emphasis on the wartime situation, are suffering those flashbacks, whether they watch "M*A*S*H" on television or what, but they are beginning to feel that.

In our own area, of course, Dr. Karl Menninger was the first head of the VA Hospital in Topeka, the famed medical mental clinic. So, we appreciate that emphasis.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Let me make a comment, since the gentleman from Kansas mentioned it.

Dr. Holsinger, before yielding to Roy Rowland, in your own opinion, your personal opinion, you are prepared that if we do have some wounded military personnel coming back from the Persian Gulf, that you are prepared, and your health-care system can take care of these wounded veterans.

Dr. HOLSINGER. That is correct, Mr. Chairman. We are prepared.

We have been working extremely hard over the last 6 months, since August 2, to make sure that we are prepared. Our plans keep going through additional iterations, and we keep improving upon them.

Our people in the hospitals keep improving on their plans. I have been in touch with a number of directors and chiefs of staff across our system over the last 3 weeks, and as the Secretary said earlier, the morale is running very high in our medical centers, as our people are prepared to play their part if they are called upon.

The CHAIRMAN. I have visited the Jackson Medical Center of the VA, which is one of the primary hospitals, and I was impressed. They even have a control room. They have computers there.

If they need an orthopedic surgeon, a brain surgeon, they can hit the computer and get that individual on contract from that area. So, I feel good that the beds are there, and they can do the job.

Dr. HOLSINGER. Thank you.

The CHAIRMAN. Dr. Roy Rowland.

Dr. ROWLAND. Thank you, Mr. Chairman.

Welcome, Dr. Holsinger. It is nice to see you here this morning.

Dr. HOLSINGER. Thank you.

Dr. ROWLAND. Secretary Derwinski, also.

I do not have a burr under my saddle. I just want to thank you all for the new outpatient clinic that we are getting at the Carl Vinson VA Medical Center in Dublin, a facility that was originally built to look after 10,000 visits a year, but last year we had 60,000 visits, and it was an almost impossible situation.

So, we are going to have a groundbreaking down there, as you are probably aware, on Monday. I am very pleased about that.

I want to go back to what Mr. Spence had talked about, and that's the professional pay bill. This is one of the most frustrating things that I have encountered in the Department of Veterans Affairs here in the Congress in trying to upgrade the pay of professional people.

It is wonderful to have the bricks and mortar, and certainly, we need to have good facilities, but if you do not have the personnel to work in those facilities, you just cannot provide the kind of care that veterans deserve.

We passed a bill last year in the House. It was stopped in the Senate. We passed it again in the House this year. It languishes in the Senate.

Can you give me some idea about what is going on, about why this bill cannot move through? Contracting out costs a great deal more than raising the cap on what can be paid. It just does not make any fiscal sense.

It is not fiscally responsible not to give the directors of hospitals the wherewithal in the communities and certain bounds that are specified in this bill, to be able to pay full-time to have physicians and other professional people on the payroll, rather than having to contract out for them.

Why can't we get this piece of legislation through? Do you have any ideas?

Secretary **Derwinski**. We are moving. We hope to have it through fairly soon.

Matter of fact, if I could remind you, Congressman, we had a similar frustrating situation with the nurses pay package. That is behind us now. That will be in effect, I believe, April 1.

It is our hope that we could have the Senate move with a bill that would then quickly be subject for House-Senate conference and be processed, and Dr. Holsinger has been working with the Senate committee ironing out the minor differences, and we are on the move.

I will yield to you, Dr. Holsinger.

Dr. **Holsinger**. Well, it is obviously frustrating to us in the Veterans Health Services and Research Administration, as well, because of the fact that it has played such a key role in our recruitment and retention, and we have been, now, working—this is the second year—trying to get the bill through.

I think we have a good bill. I think it will, upon passage and implementation, give us what we require to be able to recruit and retain the physicians that we want.

Dr. **Rowland**. I, last year, was told on several occasions that we were almost—we almost had it done, we are almost through with it, and I talked with some hospital directors who had talked with me about it. I said, well, I think it is going to be a done deal now.

I guess it is not over until it is over, but do you feel very certain at this point that that legislation is going to get through and that we are going to be able to put statute law in place that would deal with this?

Dr. **Holsinger**. Yes. I believe that the Senate will pass a pay bill, and I think that, as the Secretary has indicated, the two houses will be able to quickly come to a compromise.

Dr. **Rowland**. Well, I certainly do appreciate that. I am going to quote you to the directors that have been talking with me, if that is all right.

Dr. **Holsinger**. Well, I just told them all that just last week.

Dr. **Rowland**. Okay. Thank you. Thank you very much.

Thank you, Mr. Chairman.

Mr. **Edwards of California** [presiding]. The gentleman from California, Mr. James.

Mr. **James**. Thank you.

This is a question for the Secretary. I noticed you said that West Virginia, even though there was some complaint, apparently, from Congressman Staggers, had its more than fair share of equitable distribution of funds from the VA.

I take it you could not say that about Florida, the State I am from. Is that fair to say?

Secretary **Derwinski**. I would say Florida has done very well in recent years. You have had an aggressive delegation.

Mr. **James**. You must be kidding as far as per capita, considering the increase in population. You do not really mean that, do you?

Secretary **Derwinski**. Yes, I do, because your population increase is less than the myth that the Florida delegation continuously espouses. Our figures show that by the year 1995, your veteran population will have peaked and will start to decline.

Mr. **James**. Are you suggesting that it is a myth that there are 800,000 people in my district, as opposed to——

Secretary **Derwinski**. No, no.

Mr. **James**. Okay.

Secretary **Derwinski**. I am talking about the veteran population. I am telling you that, starting in 1995, the veterans population in Florida will start to decrease.

Mr. **James**. Okay.

There was a psychiatric treatment facility that was planned in Gainesville, FL, and it was the anticipation that it would be appropriated and budgeted for 1991. Am I correct in seeing that it is not budgeted for 1992?

Secretary **Derwinski**. Dr. Holsinger.

Dr. **Holsinger**. The facility in Gainesville, that was budgeted for in fiscal year 1991 was a parking garage.

Mr. **James**. I am asking about 1992.

Dr. **Holsinger**. The earliest that the construction dollars have been planned, as best I can tell, is 1994. Funds are not in the 1992 budget. That is correct.

Mr. **James**. So, it is still on course. There is no slowdown of it whatsoever.

Dr. **Holsinger**. There are two things that are going on in Florida.

One, we are revalidating every project in the State of Florida to have a statewide plan in order to be able to combine what we have going on as far as the construction of the West Palm Beach, Forida hospital; concerning the East Central Florida facility; the psychiatric facility at Gainesville; and a clinical addition to Tampa, so that they all meld together and we have a program in Florida that best serves the veterans of Florida.

We have slowed up the process of the design for the Gainesville facility on the basis of the fact that there is no reason to draw the plans 2 years before we can go to construction bid.

Mr. **James**. Okay. So, now it has got to be revalidated again? We do not get one, necessarily, in Gainesville? Is that what you are saying?

Dr. **Holsinger**. I anticipate that there will be some construction at Gainesville. Whether it is going to be a psychiatric facility or an addition to the medical/surgical capabilities of Gainesville, for example, depends on how we would look at the scope of all the projects in the State of Florida.

Mr. **James**. Okay. So, you realize, of course, Florida is the only district of the 27 that does not have a long-term psychiatric treatment facility. Is that not correct, or is that wrong?

Dr. **Holsinger**. No, no, that is absolutely correct.

Mr. James, you need to understand that I began my career in the VA at the Gainesville VA. I spent 4 years there. I have also spent time at Lake City, as well.

Mr. **James**. I have spent 42 years in that district, and I spent some time in Gainesville, too. So, you are familiar with it.

So, you must be aware, then——

Dr. **Holsinger**. That is my point.

Mr. **James**. You must be aware, then, where our veterans services are concerned, in my district in Florida, you cannot get any help, by and large, for a nonservice-connected disability.

You cannot get any help for medical treatment in that district, which I understand is not true in relationship to other districts, but if it is not service-connected, you do not get help in my district. You are aware of that, basically.

Dr. **Holsinger**. Well, I am aware that Florida has a need for additional health-care facilities in the VA.

Mr. **James**. Are you aware of the fact—I am asking the question—that my district is peculiar and different in that respect as opposed to many other States.

For example, in West Virginia, I assume, a veteran does not have to be service-connected to get some help.

Dr. **Holsinger**. With your specific district, I am obviously not specifically aware of——

Mr. **James**. What about generally in Florida? That is true, is it not?

Dr. **Holsinger**. Generally, in Florida, we treat fewer nonservice-connected veterans on a percentage basis.

Mr. **James**. Than most other States.

Dr. **Holsinger**. True.

Mr. **James**. Okay. So, then it would be unfair to assume, then, that there is equity in treatment in Florida because of the growth in population.

There also is no formula to adjust for the people that vacation in Florida, either in the forms or in the final computation. Is that correct?

Dr. **Holsinger**. That is true, but that is the reason why we have four major construction projects scheduled for Florida, including two completely new hospitals. There is no other State that we are doing that in.

Mr. **James**. This is the first news I have gotten that we no longer, apparently, are going to have a psychiatric treatment facility. That is still iffy, regardless of what we were told or believed last year.

Dr. **Holsinger**. I did not say there would not be a psychiatric treatment facility in Florida.

Mr. **James**. It just might not be located in Gainesville.

Dr. **Holsinger**. That is correct.

Mr. **James**. Okay.

Dr. **Holsinger**. In that case, if that is the way the plan comes out, there will then obviously have to be additional medical-surgical beds in Gainesville to offset other beds that might be shifted to a long-term psychiatric facility.

We have not finished our review of the whole situation. It may go down exactly the way it is currently planned, but since we knew that we did not have the opportunity to fund the construction for a psychiatric facility in Gainesville until the year 1994 there was no reason to waste the taxpayers' money by planning for a facility 2 years before we could actually construct it.

There would be no way of defining a facility today without having to go back and redraw the plans based upon changes in medical technology, changes in the needs and all the rest of it. It gives us a window to look at the overall scope of all of the projects in Florida and try to develop a plan that is not done piecemeal, but is done as a state-wide plan to make sure that the entire State of Florida's veteran population gets served appropriately.

Mr. **James**. Thank you very much. I see I'm out of time, but all I would ask and plead is that we get equity in Florida. I do not believe that at this point in time, the formulas are adjusted in such a way that with a fast-growing State like Florida, we're getting equity as far as dollars.

I know the system does the best it can, and I congratulate you on that, but we're falling far short in almost every area as far as my observations are concerned and from the comments I hear from other members and other people that get services in other States.

You see, I can compare what they tell us when they come down from New York and from West Virginia as to what's available there. We even have a restricted drug list as far as what is approved, and it's an entirely different ball game than it is in other States. If you want equity, then may I submit to you that those are areas in which we need equity. At least don't let us be the only district without a psychiatric treatment facility, which is apparently on down the road for many years. That is intimidating and scary to me, both as a Congressman and to my veterans. So I demand and beg for equity in Florida.

Thank you.

Mr. **Edwards of California**. The gentleman from Alabama, Mr. Harris.

Mr. **Harris**. Thank you, Mr. Chairman, and Mr. Secretary, it's good to have you up this morning. Some of your staff, I've met, and some, I haven't, and Dr. Holsinger.

I appreciate what you said about thinking nationally and about the total picture. But, you know, I find that too many folks, when they rise to be statesmen, get retired from their jobs, and so you have to be parochial, too, Mr. Secretary, as you know.

Secretary **DERWINSKI**. I understand that. I understand, except now I have no recourse but to be a statesman.

Mr. **HARRIS**. And I must admit to being surprised in the budget that a project down our way, which, according to the long-term plan, was to be in the 1991 budget, and, of course, it was not even requested by the Department, and we had some meetings, and I have letters here from you and from Tony that it would be in the 1992 budget, and part of it is and part of it's left out. I'm going to ask for a meeting; I won't take everyone's time this morning with it, but I just want to express my surprise that the entire project was not included after the assurances that I was given last time when our people very graciously didn't object and agreed to the project being put over a year. So I just hope that I don't have to go home and try to explain how one of my pockets was picked.

Mr. **PRINCIPI**. I can assure you, Mr. Harris, and we can follow this up with a meeting, that we will commit the $41.6 million for Tuscaloosa in fiscal year 1992, and that there is a need for that Building 38 renovation, and the dollars will be there. This will not slow down the project. We will be getting this project done. We will finish up with that Building 38 as a retrofit. So it will all be there. I commit that to you. The entire amount does not show in the fiscal year 1992 budget, and we can somehow sit down and talk through that figure, but the $7 million or $8 million additional funding will somehow be following on. The whole project will get done. It's not been cancelled.

Mr. **HARRIS**. I appreciate that. Thank you. Thank you, Mr. Chairman.

Mr. **EDWARDS OF CALIFORNIA**. The gentleman from Florida, Mr. Stearns.

Mr. **STEARNS**. Thank you, Mr. Chairman, and I also want to welcome the Secretary, who I admire, and Mr. Principi and Dr. Holsinger, who, as you pointed out, had spent a number of years in Gainesville. Of course, Gainesville is in my district, and obviously I'm concerned. I've known about your intention to stop the project, the long-term psychiatric facility in Gainesville. I've expressed my feelings on this matter to you folks personally and to the Secretary.

Your indication is that this is on hold until 1994. Now, my purpose this morning is more or less to get this on the official record, if you would. So if you will bear with me.

As you know, Dr. Holsinger, this program, this project was approved back in the 1970s. The State of Florida got ten acres donated for the facility, and, as Mr. James has pointed out, we have never had a long-term psychiatric facility in Florida and southern Georgia. So this would be covering the entire State of Florida and southern Georgia.

You have been in office how long? How long have you actually been in the present position you're in today?

Dr. **HOLSINGER**. Six months and 14 days.

Mr. **STEARNS**. Okay. So here, we have had a project that's been approved for at least a decade, perhaps maybe even 20 years. When

I went to the chairman of the VA-HUD appropriations subcommittee, Mr. Traxler, and he showed me a study that thick back in the 1970s that showed this particular project would go there.

It was approved, the land set up, and, as you know, Gainesville has the University of Florida with a teaching hospital, a major medical facility and teaching hospital which uses their staff to work with the veterans.

At this point, for you to be on the job 6 months and to say we're going to cancel this project, put it on hold until 1994 with the possibility of moving it elsewhere, how do you justify your 6 months' of analysis with some 15 to 20 years of analysis by the State, by the Federal Government?

Let me put that in the further light that this committee, this house of Congress, approved on the House floor the first stage in the 1989 budget, and then we approved in the 1990 budget. So you are thwarting the will of Congress, the will of the State of Florida.

All the other men and women have studied this for years, and you have been on the job 6 months. Tell me how you can justify not having it there, and tell me how you can justify having medical surgical units there in its place?

Dr. HOLSINGER. Do you want me to answer?

Secretary DERWINSKI. Yes, but let me point out that, just as a general observation, that it is far more practical to take a good hard current look at the needs of Florida veterans than to operate from a 20-year plan that clearly would be obsolete in terms of its concepts of 20 years ago.

We have an entirely new challenge in VA medicine, we have new responsibilities coming to us. We are very painfully aware of the population growth in Florida, we're aware of the snow bird phenomena, and all those calculations are going into Dr. Holsinger's effort to see that there is a totally effective equitable statewide health care system in Florida for Florida veterans.

At this point, I'll turn it over to Dr. Holsinger.

Dr. HOLSINGER. Although I've only been in this job for 6 months, I have built my entire career in the Department of Veterans Affairs. I have served in nine of our 172 VA hospitals. I have spent a lot of time in this system.

I think that with the particular team of people that I have been able to bring to Washington to work with me in these particular activities, a number of whom have been directors and chiefs of staff, that they have an ability to approach these projects and to look at them in a way that will allow us to get the best possible care to the greatest number of veterans, both in Florida as well as in a number of other areas where we're doing exactly the same thing.

We have had a tendency in the past to piecemeal our approach to construction. What we're trying to do is to re-scrub one hundred percent of our major construction projects across the country, looking at the needs, the size, the missions of every one of those facilities to make sure that we appropriately spend American taxpayers' money in a way that gets the biggest bang for the buck.

Mr. STEARNS. Let me just interrupt, reclaiming my time, if I could because I'm running out of time. What you're saying is sort of general comments. Where are you going to put the psychiatric facility if it's not put in Gainesville?

Dr. HOLSINGER. We have not made a decision.

Mr. STEARNS. Well, you must be looking at other sites if you have stopped this project. Where else are you considering?

Dr. HOLSINGER. We have not made a decision to not build the project in Gainesville. We are doing a complete look at all of our construction and all of the missions of all of the medical centers in Florida in an effort to lay down a plan that will work the best.

It may be exactly the current plan; I don't know that.

Mr. STEARNS. When you say medical/surgical units might be built there, why?

Dr. HOLSINGER. There are a variety of possibilities for locating facilities in Florida.

Mr. STEARNS. Give me, quickly, your reasoning why.

Dr. HOLSINGER. There are a variety of possible ways that we can approach where we put things. One, we could build part of the new East Central Florida Hospital as a psychiatric facility, for example, in which case we may need additional medical/surgical units in Gainesville.

We could make a mission change for Lake City, for example, and turn it into a psychiatric facility, in which case we need medical/surgical units in Gainesville. There are a variety of possibilities that may result in our being able to get long-term psychiatric beds into Florida far quicker than building them as a new unit in Gainesville.

Then again, it may work best to do what's currently planned. What we're saying is, we want to look at the whole structure of things in an effort to make sure that we get the best fit for the veterans in Florida. We're concerned about them.

I am well aware that there is no long-term psychiatric facility in the State of Florida. I served 4 years there and know the difficulty we had in placing patients as far away as Augusta and into Alabama.

But I would also remind you that the Gainesville VA Medical Center 25 years ago was originally built as a psychiatric facility for Florida and was never opened as such.

Mr. STEARNS. Let me just conclude, Mr. Chairman, by saying that, in all deference to you and your study, there have been people of your ability and foresightedness who have had the in-depth experience that you've had, who have also studied this. They've also studied it for many more years than you have, and there has been long-term analysis for veterans every time somebody has come up here to Congress and they use those words; we're making a long-term analysis.

So, the words you're saying are the same thing we've been hearing for 15 to 20 years, and your analysis could be no different than the previous administrations. They all have been trying their best to solve the problem.

What I find surprising is, after all these years, that you think that you have an insight enough to kill this facility that Congress has approved for two appropriations; an insight that all previous think-tanks on the study of long-term care for Florida didn't have. You have an insight that they didn't have, so you're going to kill it.

Last question: What are you doing with the $12 million that was approved for the parking lot in 1990? Where is it? Is it in an escrow account?

Dr. HOLSINGER. It's in our Office of Facilities construction accounts, right.

Mr. STEARNS. It's just going to stay there. You started to let the contract and at this point, the company has to stop.

Dr. HOLSINGER. We have the situation that since parking garages are handled in a revolving account once that money is appropriated and the garage is constructed, the employees and the patients end up paying for that parking. Until such time as we need to build that parking garage, we do not want to build it ahead of time and have people pay for parking.

The purpose of the parking facilities was to support the psychiatric addition. We have no construction dollars for the hospital. Congress has appropriated the funds to build a parking deck which will require paid parking at that hospital once it's constructed—when they have free parking today—and it doesn't need to be built until just before a new building is built at Gainesville.

The other thing that has been appropriated is the funds to draw the plans for a facility and have those plans, if we do that now, sit on the shelf for 2 years. That is a poor use of the taxpayers' money.

Mr. EDWARDS OF CALIFORNIA. The time of the gentleman from Florida has expired.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. EDWARDS OF CALIFORNIA. Thank you, Mr. Stearns. The gentlewoman from California, Ms. Waters.

Ms. WATERS. Thank you very much, Mr. Chairman. This is the first time that I've had the opportunity to meet the Secretary and other staff members. As a new member, I suppose I have a thousand questions, but I must limit myself to the 5-minute rule.

Let me take this time to raise some questions of you that cannot perhaps be answered at this time, but I would like for you to get back to me with information concerning a number of these items. The other items, I will attempt to get some answers from you at this time.

First, I've heard compliments to you about your excellent staff and I'm pleased to know that you have an excellent staff. I would like to get a flow chart so that I can understand the roles and the relationships of various personnel to you. I'd also like to understand your staffing as it relates to affirmative action.

I'd like to have an understanding of women and African-Americans and Latinos and others who may or may not be working, so that I can be clear about what you have or what you don't have. In addition to that, I'd like to raise some questions about your Research Unit.

Being new and not knowing very much about Veterans Affairs, I was surprised to learn of your AZT study in the newspapers and the conclusion that was reached from that study about AZT not being beneficial, perhaps, to a large segment of our population that's not had access to it. So, that information, I'd like to go over with members of your staff at some point so that I can understand the study and the conclusions that have been reached.

Now, my main concern is integration of returning veterans from the Persian Gulf into the society in a smoother and more meaningful way than I think many of us have observed from what took place with Vietnam veterans. You can't do it without money and I'm surprised, for example, as I look—let me look first at those items that are not included in your budget.

They're in other budgets, but they impact very heavily, I believe, on our ability to integrate veterans back into the society in a real way. JTPA, for example; you only have about 3,060 slots in the JTPA programs that would be allocated for veterans; is that correct?

General **GRAY**. I don't recognize your acronym; I'm sorry.

Ms. **WATERS**. I think it is Jobs Employment Partnership Training Act and it comes out of the Labor Department, except you have a little share in that. I'm wondering why the allocation isn't bigger. I'm sure that you were asked or you were included in the input in some way about what your share of JTPA training should be. If you don't have the answer now, we can talk about it later.

Mr. **PRINCIPI**. We can provide that to you later, Ms. Waters.

Ms. **WATERS**. Why don't we look at that later and talk about how you will direct those dollars, if they're set aside for veterans, in the local communities; that's very important.

Secretary **DERWINSKI**. Ms. Waters, Mr. Collins back there is the Assistant Secretary of Labor and handles that program. They're the primary entity, but we will give you all the information we can.

Ms. **WATERS**. Yes, I would like that information. I know you have to work with Labor to get that. At the same time, I'd like some information on housing for homeless veterans. I understand that that program also is in HUD.

Mr. **PRINCIPI**. Yes, it is, but we have a very, very active homeless program with many components—the chronically mentally ill; we have transitional residences and, of course, we have domiciliaries. The VA traditionally has cared for, you know, veterans who are homeless and they comprise a significant portion of the homeless in the homeless population.

Ms. **WATERS**. About one third of them in my state, I believe, has been estimated to be homeless and I just want to make sure that you don't leave it up to Jack Kemp to take care of them; that you take care of them yourself, yes.

Dr. **HOLSINGER**. We have also proposed to work with Secretary Kemp and his staff to develop a housing voucher program which will take some Congressional action. It would allow us to use their homeless vouchers also for veterans.

Ms. **WATERS**. I'm sure you'll have the support of members of this Congress from what I've seen, but I just want to make sure that you exercise responsibility and not have veterans running around in other agencies looking for benefits when, in fact, others will not, I think, be as sensitive to their needs as you will because that's your primary responsibility.

Finally, let me just say that in your TAP program, you have a little increase in there to about—I think you're going to take care of about 9,176 participants. This is your Transition Assistance Program, as I understand it.

That program and the program that trains staff—you have another acronym for that—trains staff to ensure that they know how to deal with veterans on their job rights. I think they're going to emerge as two of the most important programs to be administered from Veterans Affairs. I believe that that's true because we're in a recession, and I don't know how long it's going to go on, but many of those who left jobs are leaving jobs that may not be there for them when they return, or employers, small employers, may be reluctant to keep its commitment to veterans because of the financial difficulty that they will find themselves in.

I think you're going to have to do extraordinary work in this area to make sure that veterans know what their rights are and they can access their jobs and if not those jobs, other job opportunities. So, as I look at what you talk about and the little increase in TAP, I don't think it's enough and I think that your training program for inhouse staff to be able to help in accessing those employment rights should not be closed down. I like the idea of the centralized training.

I think there should be more effort and I think you should have more personnel in it. Let me just warn you that this problem of unemployment and education, I think, will be very, very big, and we need to do a better job.

Finally, in your Pell Grants and other resources that are available for education, I wish there was some way that we could protect veterans from being ripped off by private post-secondary schools who will take advantage of the dollars that veterans have coming to them, do little or no training, no job connection and veterans go through these programs. Many of them are a farce that we pay for and then they turn around and look back at the VA and say, help me, they didn't do anything for me. I did use my veterans benefits in order to try and get trained. I have no training and I have no job.

I think we need to do some oversight and some enforcement and use the clout of VA to get rid of some of the bad guys who are taking money from veterans but don't train them or get them jobs. Thank you very much.

Secretary **Derwinski**. May I say we did have a briefing of the staff for the freshmen members, but what we've done is I've made notes, and we'll put together a little team and make an appointment with you and come up to see you in these specific areas of your concern.

Ms. **Waters**. Mine are very specific. I don't need a generic new-member briefing; I need some specific answers to the questions that I'm raising, and I don't think they've been raised by anybody else.

Secretary **Derwinski**. Okay. Fine.

Ms. **Waters**. Thank you.

Secretary **Derwinski**. We've made note of it.

Ms. **Waters**. Thank you.

Secretary **Derwinski**. Thank you.

Mr. **Penny** [presiding]. Mr. Santorum?

Mr. **Santorum**. Thank you, Mr. Chairman. Mr. Secretary, it's nice to have you here. I want to thank you also for taking the time to visit me in my office. I appreciated that and your time there. Let me start out with my parochial interests first, and then I'll try to be a statesman a little later.

I, like Dick Nichols, last week visited a VA hospital in my district and was pleasantly informed by the director that we are replacing that facility at Aspinwall. I was just curious if that's still on target to be replaced, and what is the timing of that?

Secretary DERWINSKI. That's still on target. There is a minor glitch in, I think, the contract allocations, but it's on schedule.

Mr. SANTORUM. Okay. And do you have any idea what the completion date for that is?

Mr. PRINCIPI. We had some problems with the bids on Aspinwall. They came in much, much higher than our cost estimate, but I understand we're going to ask for reprogramming out of the working reserve, and we are going to go ahead, and that's going to stay on track.

Secretary DERWINSKI. Senators Specter and Heinz as well as your office have been in touch with us.

Mr. SANTORUM. Right. Okay. Thank you.

Now, I'll get to my statesman issues. I notice in the budget you do ask for close to a billion dollars in increase in your health care area; yet, from what I've been able to ascertain, about 90 percent of that is eaten up in salary increases and staff costs.

It appears to me that with the general trend of medical care and the cost escalating at double-digit rates, there is a question that I think is obvious as to the quality of care provided in your facilities versus outside and private facilities if technology is keeping pace, and if we are, in fact, purchasing that technology or somehow interfacing with the technology to give our veterans the best possible care.

It seems to me apparent that the numbers just don't reflect the keeping up with either current technology or current quality standards. Can you comment on that?

Secretary DERWINSKI. Well, first, let me point out that in that budget increase is an increase in nursing salaries which will make us more competitive in attracting and retaining nurses at the time of a national nursing shortage.

Mr. SANTORUM. I'm aware of that. My mother was the chief of nursing services for 30 years, so I'm familiar with that.

Secretary DERWINSKI. Dr. Holsinger made reference to the fact that the goal of our doctors' pay package basically is intended to help us first recruit and then retain the highest possible caliber of medical practitioners. But I'll leave it to Dr. Holsinger at that point.

Dr. HOLSINGER. Let me deal first with the technology issue. Part of the extra billion dollars, is the increased cost of technology.

Mr. SANTORUM. Are you saying within that billion dollars is also money for technology?

Dr. HOLSINGER. You were pointing out that our budget increased—most of it is used up for inflation and so on, and part of that is the inflationary costs that go with our technology accounts as well. So we have accounts for new equipment and replacement equipment which are expanded also because of the additional billion dollars.

We use funds from that to do a variety of things in shared services. One of the ways that we can get new technology in place and function well in our medical centers is to share that technology with the private sector or with university medical schools, where we pay for half the cost of the equipment and they pay for half, and we end up then with sole ownership of it residing with the VA, but it may be placed at either location. We have used that program very effectively to expand our technology base, particularly new technology.

Also, as we do major project design work in our hospitals, additions and other constructions when we are often able to design magnetic resonance imaging suites and also CAT scan suites and so on, and so that equipment comes on-line at the time that those facilities are activated. That's true, for example, at the Palo Alto facility.

So, we have been able to keep up with technological advances. We have some real interest, though, of going beyond simply acquiring new technology, and plan a much larger national role in Technology Assessment. We have the ability to look at new technologies across a broad spectrum of health care, which is not necessarily the case in the private sector.

The issue of quality is one that we are always concerned with. We want to provide the highest possible quality health care to America's veterans. Simply this year, fiscal year 1991, and next year, fiscal year 1992, having in each year an additional billion dollars has enabled us to at least have a current service budget, which means we are not degrading the quality; we are at least maintaining quality. Hopefully, through a variety of management initiatives, we're going to be able to continue to improve quality.

Mr. SANTORUM. Okay. I'd like to pursue that maybe at some later point because I see my time is running out, and I have one other question I'd like to ask.

Mr. Secretary, you mentioned in your briefing last week and also today about your concern for the aging veterans and that population. That's also a large concern of mine. I was just informed by the Hospital Association that the county that I represent has the oldest per capita population now in the country, which is amazing to me, but that's what we've been told, and certainly our veterans population is also old.

There is a program that we've talked about, which is the Geriatric Research Education and Clinical Centers, which I understand in the budget was funded to the tune of one additional center this year. If it is really the concern of the Department of Veterans Affairs that we pursue a course of treating older veterans, wouldn't it be incumbent that we start funding proposals like this and look to implementing more of these types of programs?

Secretary DERWINSKI. Yes, but given the constraints in the system and given the demands from all sorts of other specialties, I have to say quite frankly there is nothing more vociferous than a group of doctors coming in representing a specialty, and, without exception, every specialty in the medical field believes they are supreme and everyone else is second rate.

The point I'm making is that we have intense competition for our medical dollars as a matter of principle, and that's what I mentioned in my testimony. Over the last 2 years, over 4,000 long-term health care beds have been added, and that's——

Mr. SANTORUM. It seems to be the focus that the VA is shifting more and more toward long-term care. I'm not incorrect, the veterans population in this country is roughly twice the average age of the rest of this country. So it would seem to me that your medical facilities would be much more inclined and should be much more directed than maybe the normal medical facilities outside of the VA, the private and non-profit communities, to concentrating your efforts in an area where your population is the highest.

While I understand there's competition among a lot of other doctors for thoracic surgery and everything else, the fact of the matter is that really where your population seems to center differently from the outside is in the aging area, and I would suggest and encourage you to continue to pursue funding along those lines to better serve the veterans population.

Secretary DERWINSKI. Well, we appreciate that support.

Dr. HOLSINGER. Let me just point out one thing, Congressman. We are funding three new GRECCs this year and one more in 1992. That will take us from twelve right now to 16.

Mr. SANTORUM. Okay.

Dr. HOLSINGER. So in a 2-year period, we will have increased by a third the number of GRECCs that we have in our system.

Mr. SANTORUM. Mr. Chairman, just so you are aware, we are back in a little parochialism because we have a GRECC in our area that we're trying to get, and so I'm encouraging that. I tried to be a statesman, but I wanted to get that in.

Dr. HOLSINGER. I think you're actually in the running for one of the three, if I remember correctly, for this year.

Mr. SANTORUM. That's correct. Thank you.

Secretary DERWINSKI. I don't want you to be different from anyone else.

Mr. PENNY. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Well, I guess this is an annual type of thing, a bashing of the VA in this committee, and, of course, the same sort of thing I suppose takes place in many of the other committees.

It's a shame, really, Mr. Chairman, isn't it, because we have a man leading the VA who we know is very veteran oriented, and he hasn't told us so, I don't think and he probably can't, but I imagine the battle that he did with OMB was something that was pretty darn resounding, too.

I also understand on a relative basis, Mr. Secretary, that the budget for veterans this year is pretty good as related to an awful lot of other committee areas, if you will; but obviously, as you all have said, it's a business-as-usual budget, and certainly, this is the first time since I've been in the Congress—this is my ninth year—that this is not a business-as-usual time, and we've got to make some changes.

Hopefully, as a result of the legislation on the part of this committee, there are going to be some changes made, and I'd like to think, whether you can do it officially or unofficially, those changes, those improvements to it all, will have your blessing.

I might ask one general question before I get into the parochial. But how do you plan to handle the Desert Storm costs? I mean, it was said more than once that this budget does not contemplate that. Is that going to be a supplemental type of thing? How are we planning to do that, Mr. Secretary?

Secretary DERWINSKI. It will be covered in two ways. First, the immediate cost of any medical care that we would be asked to provide would be covered by Department of Defense as long as those injured service-persons remain in the service.

Mr. BILIRAKIS. Yes.

Secretary DERWINSKI. Now, from a practical standpoint—Dr. Holsinger could lay it out for you from a medical standpoint—we clearly prefer that if there is an injured veteran, he or she is in the VA facility being treated under those conditions, that should the decision be made to discharge them, it is far better for the continuity of their treatment that they be in the VA hospital at that time.

Now, the supplemental would then be triggered at that point. Once we have an idea of the number of patients we get, those that will, while they are in our care, will be discharged, become disabled veterans, and then when we can anticipate clearly the new demands on our system, that is what we will place before appropriate authorities and the Congress, as far as a request for a supplemental is concerned.

Mr. BILIRAKIS. All right. So, the cost associated with those men and women who would be in the VA hospitals, while they're still in the military, would come from the Department of Defense.

Secretary DERWINSKI. Yes.

Mr. BILIRAKIS. That has been worked out with them?

Secretary DERWINSKI. That's correct.

Mr. BILIRAKIS. All right. But are those dollars going to be available timely enough to be able to get out and get additional personnel that would obviously be necessary? We're straining our current system as it is without Desert Storm. So we are talking about additional personnel, additional equipment, etcetera. Go ahead, sir.

Secretary DERWINSKI. I will yield to Dr. Holsinger, but let me point out once in a while you get lucky in any business. By coincidence, in addition to having spent a career in VA medicine, the good doctor is a Major General in the Army Medical Reserve, and he knows all the players in military medicine. As a result, our coordination with the DOD in the last 6 months could not have been better, because we accidentally have the right people in the right place. I yield to you, doctor.

Dr. HOLSINGER. Well, we have clearly incurred start-up costs. During the last 6 months, we have undertaken heavy, intensive training of our people to be prepared to deal with chemical casualties and the ballistic wounds. So we have those kinds of start-up costs.

We also have costs that are attributed to a variety of different things, including an 800 number in place and skeletally manned and with the availability of people already trained to move in to act as a locator service and so on, to make sure that families can find families and friends can find where casualties might be located in the VA system.

If those costs reach a magnitude where they are serious, we may seek a supplemental appropriation.

We have for years taken care of active duty personnel in peace time and we have a means in place to bill DOD, on a timely fashion, for all care that is done for active duty personnel in our facilities. We have refined those billing arrangements even further, getting ready for the possibility of casualties from Desert Storm.

We can authorize VA facilities to spend the money against accounts receivable from DOD. So, we are in a position from day one of essentially having those dollars in place from DOD to take care of casualties.

Mr. **Bilirakis**. That is good to hear. May I have the unanimous consent for 30 additional seconds, sir, because I have not been able to get in my parochial question, if you will.

One very quick question, which would only require, I think, a quick answer regarding the Florida situation. When, Dr. Holsinger, do you plan to make that decision, and do you plan to crank in the four Floridian members of this committee into that decision before it is made?

Dr. **Holsinger**. At the rate we are going on scrubbing the plan, we would expect that the plan would be completed prior to the Secretary's decision on the East Central Florida Hospital location, which means that we are roughly looking to the end of March for that. We obviously would be happy to include the members of this committee from Florida.

Mr. **Bilirakis**. I would suggest it would be good politics, sir, particularly since there are four of us on this committee.

Dr. Holsinger, I, you know, am very hopeful. I met you the other day at West Palm Beach at a ground breaking, and I am very impressed with you. But I am very hopeful that this hold that is being put on everything taking place down there, which I assume is also taking place around the country with Florida not being the only one picked on, is the result of maybe changes in needs, a review of a medical type of a hold and a medical type of review, rather than a dollar type of review. I feel very very strongly about that. Is that clear?

Dr. **Holsinger**. That is correct.

Mr. **Bilirakis**. I am not sure that it came out quite right.

Dr. **Holsinger**. I understand what you are saying Congressman, and what we are trying to do is to look at providing the appropriate scope of services, medical service, health care services to all of Florida's veterans in the most effective way that we can, from a clinical point of view.

Mr. **Bilirakis**. Well, but I am hopeful, though, that in the process, the ground rules under which that decision is going to be made is not the result of dollars committed over a period of time to Florida being switched elsewhere because of undue pressure. Somebody mentioned, the chairman mentioned, Byrd or what not.

I would be terribly terribly upset and angry if I found out that were the case; also, I might add, disappointed in the Secretary who I just do not think would ever be a party to that. He's too tough to succumb to that sort of thing.

Dr. **Holsinger**. That is not the case. Dollars are not driving this plan. We are not looking at it because we have reduced dollars going elsewhere. Quite the contrary, we are looking at what we can do that will make our plan better meet the needs of Florida veterans.

Mr. BILIRAKIS. Thank you for your indulgence, Mr. Chairman.

Mr. PENNY. Mr. Smith.

Mr. SMITH. I thank you Mr. Chairman.

Mr. Chairman, a prior engagement precluded my being here when the hearing commenced. I would ask that my statement be made a part of the record in the hearing.

Mr. PENNY. Without objection.

[The statement of Hon. Chris Smith appears on p. 99.]

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Secretary and your colleagues, welcome to the committee.

I first want to note, at the outset, that I appreciate Mr. Secretary, your personal intervention and the kind of assistance you have provided in trying to get the Brick Outpatient Clinic opened and operating. It has been, as you know, strewn with one obstacle after another, delay after delay, through no fault of your own. You have certainly been doing all that you can to get it off the ground and to try to get it into operation.

I was wondering if, in the 1992 budget, if operational funds were included for the outpatient clinic?

Secretary DERWINSKI. Yes. But let me—let me say Congressman Smith, you are too polite. That particular outpatient clinic has been a glorified mess. We have had more damn headaches with that contractor and, ironically, the same contractor has been involved in one or two other bids, where he was the low bidder and we have had difficulties and you've been very patient. I would like to thank you for your sincere interest and your constant concern.

We think we are finally getting there. We will have the funds—that is one thing that Dr. Holsinger has done. When he came in, I told him, I did not want any situations any longer where we would build say a nursing home or an outpatient clinic and not be ready to staff it, either budget-wise or manpower wise. So, we had a situation up in Mr. Stump's district in Arizona, where they build a nursing home and it took them a year before they had it furnished, equipped and staffed. Now, that is just very poor planning and that ceased. So, when that outpatient clinic is ready, it is going to be functional with staff and everything else that goes into it.

Mr. SMITH. Are there any new estimates as to when that might occur, or is that still an open question?

Secretary DERWINSKI. Do we have anybody from construction here?

Mr. HUNKELE. Sir, the contractor is in the process of turning over one quadrant this month, and then concurrently with turning over the other quadrants VA will take about 3 months to finish their training and fully occupy.

Secretary DERWINSKI. Thank you.

Mr. PENNY. We need the name of the staff just for the record.

Mr. PRINCIPI. Les Hunkele, Deputy Assistant Secretary for Facilities.

Mr. PENNY. Thank you.

Mr. SMITH. Mr. Secretary, on August 15, 1990, President Bush signed into law P.L. 101-366. The law established the Reserve

Member Stipend Program which is administered by the VA Scholarship Program Division.

In the VA's budget request, there is, as far as I can tell, no mention of the new program. I am interested in knowing if the VA plans to fund the program and what you would estimate to be the approximate cost?

Dr. HOLSINGER. I can answer that question, Mr. Smith. In fiscal year 1991, we will fund 200 grants for reserve member stipends, totaling about $1.8 million, and those stipend awards will be made in time for the fall semester.

The reason why it is not shown in the fiscal year 1992 budget is because the new legislation was not enacted until after the time the fiscal year 1992 budget was put together. We plan to use funds within our scholarship program to be able to handle reserve stipends in fiscal year 1992 as well.

Mr. SMITH. Very good.

Dr. HOLSINGER. But we will be funding those starting this year.

Mr. SMITH. One final question, Dr. Holsinger. I've been on this committee now for 11 years, and for the last eight or nine we've been hearing the recurrent concern that there is at least a $700-$800 million need for medical equipment that has gone unmet. You did provide in the budget $143.7 million for medical equipment. I was wondering if we are making real progress on that medical shortfall in terms of equipment in our health care facilities?

Dr. HOLSINGER. First of all, one of the things we are undergoing right now is an absolute scrub of our backlog of equipment. We want to make sure that those requests and needs are current so that we can come up with an accurate list. After this review, we will know what we're really talking about as far as costs and what kind of equipment backlog we have.

The funding in the budget will certainly keep the backlog from increasing in fiscal year 1992.

Mr. SMITH. Thank you. I yield back the balance.

Mr. PENNY. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, first of all, I want to thank you because I believe your open-minded attitude on Agent Orange has resulted in the legislation that the President recently signed, and it was a big momentum to helping us put that issue behind us. So, we very much appreciate your leadership in that issue and the fact that when you came in you said you'd take an objective look at this issue and you clearly have. I think Vietnam-era veterans who were affected by Agent Orange exposure really look to you for thanks for your leadership on that issue.

Secretary DERWINSKI. Well, if I may say, everybody helped. You, Senator Daschle, and the chairman all worked at it and so now we have a formula for a new study which we hope will stay above controversy and will be practical and applicable.

Mr. EVANS. All right. Well, thank you.

I noted that earlier in the testimony I think Tony had mentioned or someone had mentioned that we wanted to expand the Post Traumatic Stress Disorder counseling to the post Vietnam era veterans. I understand you will be proposing legislation to do that. That is certainly something that I would support.

My question is, along with the eligibility expansion, will you be seeking in the budget any major expansions beyond those that you indicated earlier, in terms of the clinical teams, the new sites, if we have a substantial number of casualties coming out of the Persian Gulf, would there be room in a supplemental appropriation for additional vet centers, staff, clinical teams and research?

Mr. **Principi**. We have submitted the legislation, Mr. Evans, so that is here at the committee. The budget does not call for any additional sites or personnel; but certainly if the need dictates, then we will seek supplemental funding.

Mr. **Evans**. All right. I guess last year's reconciliation provided the additional funding for the additional sites that you had talked about earlier?

Dr. **Holsinger**. That's correct, yes.

Mr. **Evans**. Okay. A recent IG report on the VA DOD back-up suggests only 82 percent of the VA's reported operating beds are opened, staffed and fully ready to receive patients. The VA reports approximately 70,000 operating beds. What percentages of VA-operating beds are opened, staffed and fully ready to receive patients today?

Dr. **Holsinger**. That number is still essentially correct. Of our acute care beds, we staff, normally, an 80 percent occupancy level, and we run somewhere between 75, 82, 83 percent. So, the number is still approximately correct; it is about 82 percent of our acute care beds that are staffed and ready to use.

Mr. **Evans**. All right. Now I was at the Iowa City, Iowa facility over the break, looking into their role as a potential secondary back-up center for the Department of Defense, in case we do have some kind of substantial casualties coming out of the Persian Gulf operation. My big concern, coming out of that meeting, was while I thought they had it fairly well planned in terms of what their contingency plans with the DOD was, they were being affected by something perhaps that DOD and VA don't anticipate, and that is the call-up of reservists within that particular institution.

On the one hand, we have a contingency plan, it seems to me premised at least perhaps on 80 percent of the beds being not only available, but fully staffed; but on the other hand of government, basically the military is calling up mostly nurses, at least in the case of Iowa City, but quite often very skilled nurses that I don't think you can easily replace within a given institution, or perhaps systemwide.

I don't know if you have been able to look at that issue, or will be looking at that issue. I think all of us hope that we won't have substantial casualties, but I think all of us feel we have to be prepared for the worst case scenario where there might be a lot of casualties.

Would you care to comment?

Dr. **Holsinger**. Yes, Mr. Evans, we have. The bed availability reports that we do on a daily basis take that into full consideration, when we say staffed beds, that takes into consideration all reservists called up.

We have lost about one and one-half percent of our staff, around 3,000 individuals. That obviously, across a whole system, is not a major problem. However, in certain areas where we have distinct pockets where individuals have been called, it does have a major impact on particular hospitals. Since our plan is an iterative plan, we keep refining it daily, we have actually made changes just in the last week on primary and secondary hospital assignments, specifically because of hospitals having had reservists called and no longer being able to take a primary role, and we have switched them to a secondary role and put another hospital in place as the primary. So we are constantly aware of that problem and working on it.

Mr. **Evans**. All right. I will be pursuing this—I don't mean to make this parochial—but I will be going to some of the Illinois hospitals that have been designated as primary and secondary back-up centers, and will be pursuing this issue, and I look forward to input with you.

Dr. **Holsinger**. That will be fine.

Mr. **Evans**. Okay. Thank you very much.

Thank you, Mr. Chairman.

Mr. **Penny**. Thank you.

Mr. Secretary, it is evident that the VA budget for the coming fiscal year is not everything that you requested; and it is clear from the questions from the membership here this morning that it is not everything members of this committee wanted.

Given that, generally how do you react to the over 100 bills that have been introduced so far this session which would expand and increase veterans benefits and veterans services in various ways?

Secretary **Derwinski**. I have the disadvantage of having been in Washington for a long time and, as a result, I tend to be realistic. I have never worked off a wish list; I have worked off reality, and assets in hand.

General Gray and Dr. Holsinger made excellent points in the infighting we have to go through with OMB. The figure they have provided to us, by and large, is something that we will live with, of necessity. We think that in the last few years, our budget increases in the medical side have enabled us to catch up with some of the slippage of previous years.

It is very difficult to anticipate just what the real cost of Desert Storm will be, and that is why we will rely on a supplemental. We have been assured that there will be a supplemental, and we are just going to do the best we can to emphasize to the Congress and to our friends in the veterans world that we need constant attention. The veteran tends to be forgotten in times of peace. Now that there is a war effort going on, and everybody has rediscovered veterans as well, and a year or two from now, that will fade away again, and we are going to try to take advantage of the tremendous reserve of good will that is showing itself again, and hope that that will be reflected in our overall budget considerations.

Mr. **Penny**. Do you know of any areas of veterans service or veterans benefits that we haven't already provided, anything that needs to be done now that we don't already have in place?

Secretary **Derwinski**. I think you have been very helpful, especially in the number of bills that were quickly passed this session. You recall earlier we discussed the doctors' pay package, medical pay package we hoped to wrap up. We now will be competitive in the nurses' pay area, and those are the two major elements.

Long-term nursing homes is another area where we will be investing steadily over the years, of necessity, and we are trying to realistically face up to these challenges.

I again have been around town long enough to know you just don't throw money at something. We have a responsibility to manage the VA better than it has been managed before, and we are making some tough decisions, and we are holding people accountable. The buck stops now, from time to time. People are held accountable for their actions or lack of them.

There is room for improvement in management. It isn't just a matter of dollars, but the dollars are always helpful.

Mr. PENNY. To be a little more specific, let me ask your reaction to a proposal to double the death benefit, the SGLI insurance benefit, from $50,000 to $100,000, retroactively.

I guess the question I have is specifically——

Secretary DERWINSKI. I think that is still under consideration.

Mr. PENNY. The retroactivity of that proposal, and whether that is wise from a public policy standpoint?

Mr. PRINCIPI. I understand that the increase in the Servicemen's Group Life Insurance from $50,000 to $100,000 would be retroactive to August 2.

Mr. PENNY. As a matter of public policy, is it the right thing to do, to make that kind of an increase retroactive?

Mr. PRINCIPI. That is a tough call. I'm concerned at who is going to fund it, again.

Mr. PENNY. Okay. That's a good enough answer.

What about retroactivity on GI Bill benefits, increasing them by about 50 percent retroactively? Is that also good public policy?

Mr. PRINCIPI. Well, I know how near and dear the GI Bill program is to this committee, especially to the chairman, but again, that would be very, very costly. The GI Bill was intended as a recruitment tool. It has succeeded in being a recruitment tool, and it continues to be a good recruitment tool today. Given the cost and the fact that it has succeeded at the current levels, the Administration does not support an increase in the GI Bill benefit. It would cost $2.4 billion over 5 years, and we are concerned, of course, about the cost in this era of enormous fiscal constraint.

Mr. PENNY. I appreciate that.

The CHAIRMAN. Would the gentleman yield?

Mr. PENNY. Yes.

The CHAIRMAN. I know the gentleman's feelings, and I understand that certainly we have got to be concerned about the cost of this readjustment package—I call it an appreciation package for our Persian Gulf veterans that come back—but I think realistically, as you mentioned, Mr. Chairman, there have been over 100 bills introduced. We are going to get some type of readjustment package. I think that this committee and some of us certainly should be involved in not letting anybody take it away from us, like the Armed Services Committee.

But we are going to get a readjustment package, we are going to get life insurance, we are going to get educational benefits, we are going to get direct home loans; we're going to get a lot of things. I will do all I can to keep the costs within a reasonable area, but I think we have got to realize downtown and on this committee that some type of readjustment bill is going to come out of this committee, in my opinion.

Mr. BILIRAKIS. Would the chairman yield for one moment?

The CHAIRMAN. Yes, I will yield.

Mr. BILIRAKIS. Just very quickly, life insurance has been mentioned both by you and Chairman Montgomery.

As I understand it, life insurance plans are self-sustaining, are they not?

Mr. PRINCIPI. No, they are not.

Mr. BILIRAKIS. They are not?

Mr. PRINCIPI. Only in peacetime. For Servicemen's Group Life Insurance, the premiums cover the costs during peacetime, but in wartime that all comes out of the U.S. Treasury. Anything, any debts occurring during wartime, of course, would be borne by the U.S. Treasury. So it's not self-sustaining.

Mr. PENNY. I think the other key, Mr. Bilirakis, is that if we make the increase retroactive, that certainly hasn't been accounted for——

Mr. BILIRAKIS. I can understand that, but I guess what I'm saying is I have the NSLI life insurance, I've had it now for almost 40 years, and I get a dividend check. So apparently what is in place is self-sustaining, and it's all part of that same pool. Possibly those dividend checks can maybe help to pick up the retroactivity, if you will, in the wartime problems. I don't know. I realize you gentlemen work with it a lot more than I do, but I guess I'm wondering why we may have a reluctance to increase those amounts.

The CHAIRMAN. Would the gentleman yield?

Mr. BILIRAKIS. Yes, sir.

The CHAIRMAN. The Senate has introduced a bill to raise it doubled from $50,000 to $100,000. The bill we have introduced is from $50,000 to $75,000, and we are concerned about the costs. Will it just include the Persian Gulf, or will it include all veterans? If it just includes those who would lose their lives in that part of the world in combat, then the cost, in my opinion, would come down further than losing your life in Fort Benning, Georgia.

So there are a lot of combinations, is what I'm saying, that we can look at and work at, to kind of have the costs within a reasonable——

Mr. BILIRAKIS. Yes, sir, as long as we all work together.

The CHAIRMAN. That's right.

Mr. PENNY. If I might wrap up with the Secretary, are we ready to move on to the next panel?

The CHAIRMAN. Yes.

Mr. PENNY. I don't know of anyone else who wants to ask questions.

My last concern is, given the fact that there is going to be an appreciation package of some sort, based on the war in the Gulf, where would you place funding for increased staffing in the VA medical system, taking into account that over 4,000 beds are unstaffed now? And where would you place the increase in the number of veterans benefits counselors who are, I think, going to be in greater demand once this conflict ends? And, other staffing regional offices to react to some of the increased demand that is going to be a consequence of this war, so that we don't have a backlog of work and people standing in line? Where would you place some of these shortfalls on your priority list for funding, as compared to some of the other ideas that have been suggested in the bills introduced in Congress so far this year?

Secretary DERWINSKI. We would hope to recover in the supplemental the costs that we could clearly show are the direct result of Desert Storm, whether it be the casualties and let us hope and pray they would be minimal. When those units come home, those Reserve and Guard units, that triggers a flood of requests for benefits and counseling, and we would like to beef up Mr. Gray's staff at that point, and the hospital staff adjustment would directly depend on the flow of casualties. That is where we are counting on the supplemental for it.

Mr. PENNY. There are some—the veterans benefits counselors and other positions—are costs that will occur over several years beyond the Gulf War. Not all of these are going to be attributable to the short term.

Secretary DERWINSKI. That is right, but once we get them, we intend to hold them, hope to hold them.

Mr. PENNY. Again, I am just curious.

Secretary DERWINSKI. The load will be there, both medical service as well as benefits counseling and the processing.

Mr. PENNY. Would you say that those staffing and funding needs would be a higher priority than increasing the GI bill benefit? I am the Chairman of the Education Subcommittee, and you are not going to offend me by an honest answer.

Secretary DERWINSKI. In the absence of an official Government position, I will give you my personal opinion, which is yes.

Mr. PENNY. Thank you.

Mr. Secretary, I do not have any further questions, unless the chairman or Mr. Evans or Mr. Bilirakis have additional questions of you and your staff. I think this has been a very productive morning session. We appreciate your time and your effort on behalf of America's veterans.

Secretary DERWINSKI. It is always a pleasure to appear before this committee. It is always an interesting and, actually, pleasant experience for all of us.

Mr. PENNY. For us, as well. Thank you.

Our next witness this morning is Hon. Thomas E. Collins, Assistant Secretary for Veterans Employment and Training. It is my understanding he will be accompanied by Mr. Jeffrey Crandall, the Director of Field Operations, the Department of Labor.

Mr. Collins, welcome. This is the second time in 2 days that we have had the pleasure of sharing a microphone.

Mr. Collins and I participated in a "For Veterans Only" TV program yesterday, where we discussed some of these same issues.

Rather than proceed with your testimony, I think we are going to move on to questions directly, because there are just a few basic areas I think we need to cover.

STATEMENT OF THOMAS E. COLLINS, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING; ACCOMPANIED BY JEFFREY CRANDALL, DIRECTOR OF FIELD OPERATIONS, DEPARTMENT OF LABOR

STATEMENT OF THOMAS E. COLLINS

[The prepared statement of Mr. Collins appears on p. 117.]

Mr. Penny. If I might ask you—I know we have been working with your Department for some period of time to get legislative recommendations about the implementation of the DVOP program within the Federal bureaucracy, and we are hoping for some progress on that issue in the very near future.

Can you give us an update on where that stands?

Mr. Collins. In our budget request, Mr. Chairman—and good morning—and members of the committee, the major part of the DVOP program was based upon the Vietnam-era, which after 10 years is due to sunset December 31, 1991.

That portion of the DVOP program was not funded in the request.

Mr. Penny. Would you fly that past again? They did not fund your request?

Mr. Collins. The part of the DVOP program that is based upon the Vietnam-era formula——

Mr. Penny. Yes.

Mr. Collins [continuing]. Which would sunset December 31, 1991, is not included in the request.

I might add that our budget was prepared before war broke out. We are very sensitive to continuing veterans programs and being prepared to meet veterans' needs as I and the Secretary of Labor have committed ourselves to welcoming back home with open arms and into the labor market those men and women who are serving currently in the Persian Gulf.

So, we do not wish to appear insensitive, and certainly, as this Congressional session plays out and we receive an appropriation later this year, I would like to work with this committee and this Congress in designing a program to meet not only the needs of the Vietnam-era veterans but the needs of today's veterans and, perhaps above all, the needs of tomorrow's veterans.

The Chairman. Would the gentleman yield?

Mr. Penny. I would yield to the chairman.

The Chairman. We just passed legislation I think the Senate is going to act on in the next day or two that extends the DVOP program for another year.

Mr. Penny. Four years.

The Chairman. Four years.

Do you intend to go forward and ask that the Administration ask for these funds, to ask the Appropriations Committee?

I guess if we do not get the funding, we have not really done much, and this is really the key time that we need these DVOP people, as these veterans come home, and we are going to have a lot of them, and then we are going to have over 250,000 reservists who will be back, I hope, before long that are going to be looking for jobs, cannot get jobs, and of all the times to do away with the program—are you going to ask for this money, Tom?

Mr. Collins. Yes.

Mr. Chairman, we are considering, as we watch Desert Storm unfold, coming back to the Congress, to this committee or to the Congress, with perhaps a different proposal, because we are committed to meeting the needs of those who are serving in Desert Storm and of our veterans.

How that would specifically relate to the, as I understand, extension of the Vietnam-era program, which is underway right now—I am very well aware of that—I am not sure or able to state an amendment that would come from the Administration at this time, but we certainly already have it under consideration.

Mr. Penny. That would also, I think, relate to the affirmative-action policies within the Federal bureaucracy, and I think we would expect that the Administration would be attuned to the increased demand for that particular benefit, as well, and we have had some trouble getting that coordinated among the various agencies.

Where do we stand with our policy toward affirmative action throughout the Federal bureaucracy at this point?

Mr. Collins. I would be remiss if I tried to represent the entire Administration on the affirmative action programs.

We in the Veterans' Employment and Training Service, however, become involved in the Office of Federal Contract Compliance Programs, which basically says that Federal contractors must have affirmative-action programs in their hiring of veterans and, in particular, disabled and Vietnam-era veterans. So, we are involved in that.

We collect data, and the OFCCP, another agency in the Department of Labor, actually has the audit or inspection and enforcement authority in this area.

So, as an agency head, I do keep up with affirmative-action matters, including our own Civil Rights Division in the Department of Labor, and certainly, the matters that are under the purview of the Office of Personnel Management, but please do not consider this a complete report on the entire Federal Government's affirmative-action program.

The Chairman. Would the gentleman yield?

Mr. Penny. Mr. Chairman.

The Chairman. I think what you are saying is, Tom, that if it was your personal druthers, you would ask for it, but you have to clear this with others to ask about the funding of DVOP to make the request. Is that what you are saying?

Mr. Collins. The funding of the DVOP program would certainly, at this point in time, since the Administration request has already been submitted and lacked funding due to the sunset provisions, would have to come back to OMB in the form of an amendment or perhaps later on, after an appropriation, a supplemental to fiscal year 1992, and if the legislative authority is extended, as I understand it is in the process of being now, we in the Administration have already prepared to certainly consider and work with the Congress in funding that program or designing a program, as I said earlier, that would not be based upon basing our resources upon a linkage to a conflict that is almost 20 years ago.

We need to focus—this year we need to focus on redesigning a program that would serve not only the Vietnam-era veterans—certainly, they continue to be a large group, a high share of the veteran population in the labor market—but it would also serve today's veterans, meaning post-Vietnam-era veterans, as well as those veterans that will be coming out of Desert Storm.

The CHAIRMAN. Well, I guess I am getting the feeling from you that you are not going to ask for it, and we do not know what we are going to get.

Thank you.

Mr. PENNY. Well, I hope that there is a little bit of an interest on the part of your office in helping us pursue this. You seem to recognize that there is a need for ongoing assistance in this area.

The legislative vehicle is already moving its way through the process here, and it would be helpful if we could get some support from the Administration, given the fact that you recognize the need to extend that program.

But we also I think are going to be taxing the Transition Assistance Program pretty heavily in the next number of months. Once the Gulf War winds down, we'll have 200,000 members of the Guard and Reserve returning home. The stop-loss policy will be lifted. That will allow a large number of servicemembers to be discharged. There will be 200,000 individuals who would normally leave during the course of a year and we may have a military personnel draw-down that may cause some other reductions in our force structure.

All of that indicates to me that our policy of trying to reach servicemembers before discharge to give them employment and other counselling assistance is going to be at peak demand in the next year or two.

How well prepared are we going to be for all of that?

Mr. COLLINS. We will be prepared through the Transition Assistance Program that was designed long before, first of all, there was the realization that we would now, with the world situation being what it is, would downsize the military force. Now that we are involved in conflict still with the long-range goal of downsizing the military, we have now tested or are into one year of testing through our seven State pilot project a Transition Assistance Program, which in its simplest form is an early intervention, bringing employment services to the soon-to-be veterans, the men and women currently still on active duty, a very simple concept.

We are prepared to do that this year. In fiscal year 1991 we have for the first time a line item funding for that, only a little less than a quarter of a million dollars.

In the 1992 request we are adequately funded, with slightly over $2 million that would be——

Mr. PENNY. And do you feel that is adequate for the level of demand that we are going to experience due to all these factors?

Mr. COLLINS. As we prepared our planning, that is adequate in the administrative budget. That is in our administrative account in the Veterans' Employment and Training Service. That would be adequate for us.

Please realize that there are many other resources that are going into the transition assistance effort, from our partners, the Department of Defense and the Department of Veterans Affairs. Many of these resources are in-kind, though the administrative funding that we need in the Veterans' Employment and Training Service is adequate.

Of course, with more funding we could do more things. We are not purchasing services. We are not purchasing placement services and many other things that we could add to the program but currently they are not part of the plan, nor were they a part of the original plan.

Mr. PENNY. Certainly you must develop some models based on certain levels of demand for this assistance.

Can you share with us how you arrived at the $2 million figure and what level of service that will provide and what you could do with additional amounts, how many additional service members could be served, what additional services could be offered, et cetera?

In preparing your budget request, you must have run the numbers and the budget request would then also be easily adjusted based on a higher level of demand. Of course, I think we are going to see a higher level than you might have anticipated months ago when you began developing your budget.

Can you give us that kind of information or do we have to look elsewhere?

Mr. COLLINS. Yes, Mr. Chairman, I'd be happy to respond in writing to that. We have obviously done quite a bit of work in planning, developing various contingencies including budget factors.

To very briefly answer the series of questions, the very basic model of our Transition Assistance Program is using existing resources for the most part, though under the military basis, and provide a 3-day workshop to provide job information and individual counselling and skill development to prepare the service members to become veterans and enter the labor market. That's the basic model in a nutshell.

We have the seven State pilot. We do plan in 1991 to expand that to ten States and the 1992 request, which is really what we are focusing on today, with slightly over $2 million, which is a dramatic increase in the funding this agency has had for such an effort—we first funded it out of hide. We now this year have a small amount of money, a quarter of a million dollars.

We have developed various budget plans. We will expand to 36 States. That will serve approximately 90 percent of the discharged veteran population. This would create a number, I believe it is around 1,200 to 1,400 workshops and serve approximately 60,000 new Veterans in fiscal year 1991.

Those figures are based upon our best estimates, and I must emphasize estimates because we have no hard data to go on.

We, meaning the Government, the Department of Defense, certainly cannot give specific figures on how many will be discharged, when, where and on what schedule so we have done the best estimating that we can and remember, it is a voluntary program with the exception of certain military commanders who have the discretion and may if you will and know what I mean require it to be mandatory but officially it will be a voluntary program.

We have estimated the package for 1992 using $2 million of administrative money——

Mr. PENNY.To reach 60,000.

Mr. COLLINS (continuing). To reach 60,000.

Mr. PENNY. Well, clearly we are going to have a better idea whether that number needs to be increased in a very short period of time. Hopefully, the Gulf situation will be resolved and we'll then have a better indication of how soon some of these servicemembers will be discharged and if those numbers need to be adjusted upwards. Then, of course, the funding levels will have to be adjusted upwards as well.

Mr. COLLINS. Yes, I'm well aware. We do have some surge capacity, and again, relying on our partners, the Department of Defense and Veterans Affairs, and of course I will certainly notify you on this committee and this Congress should we run into emergency conditions.

Mr. PENNY. Well, as you can probably guess, my key concern is that we do an adequate, frankly better than adequate, job of responding to the demands of our soon to be discharged servicemembers, whether it happens to be their health care needs or VA benefits counselling or these job service assistance programs which you administer.

The worst thing we can do for our Gulf soldiers is to bring them back and let them stand in line waiting for services that they are eligible for but are not immediately available to them because we haven't prepared administratively with staffing and the rest to handle these needs.

If we are going to put any money into the VA area or into the veterans area generally, that's where I think the money has to be spent, because otherwise we're going to have a bunch of frustrated veterans and that's no way to bring them home.

With that, Mr. Chairman—or Mr. Bilirakis, are there any further questions of Mr. Collins?

Mr. BILIRAKIS. Well, I guess I have one generic question. It's maybe a difficult and sensitive one, and Tom, I don't mean to put you on the spot although I guess in a way it does.

You have been through it—I mean your background in the military in those tough years, et cetera.

This reduction is 77 percent on the DVOPs. The apparent recommendation, and I am not sure whether it came out exactly that way, but the apparent recommendation, as I see it, is that the National Veterans' Training Institute be defunded.

What are the needs out there? I realize you have a job to do; and I realize that money does not grow on trees, although many people in the world think it does, and there is only so much to go around, and that sort of thing. But we have to know what the needs are and try to meet those needs. We cannot take some of those needs and hide them behind a building someplace and basically pretend that they do not exist.

Because of your background, your experience, and that sort of thing, you have to be qualified to be able to answer that question, unless, of course, there are restrictions upon you because of your job, working for the Administration. It's sensitive, yes. I do not know how you might respond to all that.

We know that the National Veterans' Training Institute has been working. We have that impression. My impression is that you feel its purpose has been basically satisfied. I think that is kind of news to this committee. Others are part of that subcommittee, and I am not. The DVOPs, are, I think, a highly, highly critical need.

What do you think? Do you personally go along with these cuts? Do you personally feel that these needs have been adequately met in one case and are being met adequately in the case of these great reductions in DVOPs?

Mr. COLLINS. Thank you, Mr. Bilirakis, for providing the opportunity to comment on this very important area, the area being training. The National Veterans' Training Institute is our training function, and, perhaps a little unfortunately, we all know what happens to training in very austere and severe budget constraint times. Training appears to be more of a luxury.

We are certainly not saying that there is not a training need remaining in the Veterans' Employment and Training Service. We have, on the other hand, however, I am happy to report that the National Veterans' Training Institute, and that system, has done an outstanding job in training our cadre of DVOPS, LVERs, our Federal staff, and even others. We cannot say that there is a tremendous shortfall in training at the present time.

We have trained in the basic professional levels employment course essentially 100 percent of our State contract personnel, the DVOPs and LVERs. We have trained practically all of our Federal staff in the Veterans' Reemployment Right Course.

So when we add up the numbers, it shows that the National Veterans' Training Institute currently has done an excellent job with the current staff and the budget request in these times of very severe constraints—not that I did not try to fund the $2.9 million optional contract——

Mr. BILIRAKIS. Well, you say you did not try to fund it. Does that mean that you——

Mr. COLLINS. We certainly had a plan.

Mr. BILIRAKIS [continuing]. That you did not try to fight the defunding of it, or did you recommend the defunding of it?

Mr. COLLINS. We certainly had a plan that would fulfill the contract and meet training requirements within the Veterans' Employment and Training structure, and through the budgetary process it was simply decided that this was not an appropriate use of the limited funds, especially in light of other budget conditions.

Mr. BILIRAKIS. Are you at liberty to tell me whether you agree with this decision made by whoever?

Mr. COLLINS. I can say that I certainly developed a plan that indicated, based upon training needs, and that we had entered over 2 years ago into a contract that would provide for a training institute.

Mr. BILIRAKIS. So you felt that it was necessary to continue in that regard?

Mr. COLLINS. Having been involved in training in my earlier life, I certainly realize the importance of training.

Mr. BILIRAKIS. Right. I would think you would more than most, well, any of us, probably.

Mr. **Collins**. Budget authorities have simply said that this is not affordable.

Mr. **Bilirakis**. I know. And we never get the budget authorities before this committee; it is always the people like yourselves that come before this committee.

Just one final question. In your opinion, if you had it to do, you would probably continue the National Veterans' Training Institute and you would probably not have reduced DVOPs by the 77 percent figure, or reduced them at all, if you had it to do, if you were King?

Mr. **Collins**. Yes, should there be adequate funding. In other words, if I had a blank checkbook.

Mr. **Bilirakis**. The need is there. Is that what you are saying?

Mr. **Collins**. The need was there. I would also provide for the DVOP program, making the changes that I discussed earlier, that I will not go back into.

Mr. **Bilirakis**. Yes, sir.

Mr. **Collins**. It is time to focus away from one conflict that was 20 years ago, and encompass all veterans.

Mr. **Bilirakis**. Yes, but those people out there are still in need, regardless of the fact that it is an older conflict.

All right. So basically what you are saying is the need is still out there. Thank you.

Thank you, Mr. Chairman.

Mr. **Penny**. We do not have any additional questions for you, but we do appreciate the time you have spent with us this morning, and we will be working with you to clarify the funding levels and staffing levels for some of these veterans assistance programs.

Again, we think the demand is going to be higher than projected in your current budget request, and that is something we are going to have to account for before the year is out, and we look forward to your cooperation in that effort.

Thank you for your time this morning.

Mr. **Collins**. Thank you very much.

Mr. **Penny**. The last panel that we have is from the Court of Appeals. Hon. Kenneth Kramer, Former Member of the House, Associate Judge; Hon. John J. Farley, III, Associate Judge; accompanied by Deborah Creek, Budget Officer for the U.S. Court of Veterans' Appeals.

While you are settling in, I am going to make my apologies, because I have a Hunger Task Force meeting to attend, and Chairman Montgomery is going to retake the Chair here.

The **Chairman** [presiding]. I want to apologize to our two judges and also the last witness that you had to wait around and talk to our Chief Counsel. Next time, we can give you notification of 15 or 20 minutes as to how it's going on the panels and you would not have to wait around.

We'd be glad to hear your statements and without objection, your whole statement will be put into the record. You may proceed in any manner you'd like to.

STATEMENTS OF HON. KENNETH B. KRAMER, ASSOCIATE JUDGE AND HON. JOHN J. FARLEY, III, ASSOCIATE JUDGE, ACCOMPANIED BY DEBORAH T. CREEK, BUDGET OFFICER, U.S. COURT OF VETERANS' APPEALS

STATEMENT OF HON. KENNETH B. KRAMER

Judge **KRAMER**. Thank you, Mr. Chairman. I'll be very brief. We'd like to first thank you personally and your staff and the members of the committee for their cooperation and support of the Court, to say nothing of its creation. We learned from Mr. Fleming this morning that there's even today, legislation that's potentially pending in front of the House that impacts upon the Court and its operations.

Chief Judge Nebeker, who could not be here today, has, as you indicated, submitted his testimony for the record. We're here primarily to answer your questions.

One area that I would like to point out that is referenced in the testimony and also in the larger submission of the budget estimates is the area of unrepresented appellants who are coming in front of the Court who are having an impact in several ways. Approximately two-thirds of the cases that are coming in front of the Court, specifically, 64 percent, involve veterans or dependents of veterans or others who are entitled to certain benefits who are unrepresented by counsel and are, in effect, representing themselves.

This has an impact on the Court's operations in terms of the resources of the Court because these people are not familiar with legal processes and, in many cases, must be dealt with individually, not only by written communication, but by telephonic communication from various members of the Court staff to help them through the process.

Perhaps even more important in terms of the committee's knowledge and information is the fact that it's simply very difficult for these people to perhaps get the full scope of judicial review that the committee anticipated when it passed our enabling legislation. We're doing the very best that we can with this situation. It's still evolving, but it's one that we wanted to point out to the committee in terms of the committee's information about the Court and one in particular that we wanted to highlight and make the committee aware of.

Other than that, Mr. Chairman, I know that Judge Farley might want to offer a perspective that he has, in particular, and then we would be delighted, either the two of us or Deborah Creek, our Budget Officer or Deputy Clerk, Jim Caldwell, who is also here today, to answer any questions that you might have about any of the issues that are facing the Court.

The **CHAIRMAN**. Judge Farley.

STATEMENT OF HON. JOHN J. FARLEY, III

Judge **FARLEY**. Good morning, Mr. Chairman. I would just like to second my colleague's remarks. Thank you very much for having us. We very much appreciate your support as we are now into our second year of this new venture. It remains an exciting voyage that we're on. The building of the jurisprudence is, for me personally, very exciting as we go on this, and I just want to thank you very much.

We're happy to respond to any questions you have.

The **Chairman**. I have several questions before I yield to the gentleman from Florida. We do have a bill today that does affect you that will be coming up this afternoon at 2 pm. It shows your caseload has increased.

Is that what you're saying, Judge Farley, that cases are coming in now?

Judge **Farley**. Yes, they are, Mr. Chairman. We're averaging now about 180 to 190 a month, so, yes, they are sure coming in.

The **Chairman**. You are actually making final decisions on 180 to 190 cases a month?

Judge **Farley**. Those are the ones that are coming in. The case process takes, as Judge Kramer was indicating, particularly since two-thirds of our cases are pro se, it takes time to develop the case and get it ripe for a decision. We have issued—all 7 judges, since about September—and we've issued about 4 opinions.

During that time, I think we've disposed of 400 cases, so we are very active.

Judge **Kramer**. I would point out for the committee's information that there are approximately, I think, around 1,500 cases that are pending presently in front of the Court. Of those, only a very small percentage are what we would call at issue; in other words, they're ready for a judicial disposition. Probably about one fifteenth of those 1,500 are ready for disposition.

The others are still, in effect, submitting the various documents that are necessary in order to get the case in a posture where it could be decided by a panel of judges. One of the reasons—and I'm not saying that this is the only reason—but one of the reasons that that process is especially long and somewhat cumbersome is because so many of these people are representing themselves and it is not an optimal situation in basically being able to bring a case to fruition in the optimal amount of time.

The **Chairman**. You mention about some of the veterans come up there without attorneys. I guess I really don't have much problem with that. I would hope that the different veterans organizations would offer that service for them and I think you have that problem, as I am told, in other Circuit Courts; that some of them do appear before the Court without attorneys. I know it maybe makes your work a little harder, but probably, in the type of court that you've got, there will be a high percentage that will not have attorneys.

Judge **Kramer**. Well, that has been our experience to date. We have approximately, it is my understanding, about five to six times the number of unrepresented appellants in our Court than would be true in a general U.S. Court of Appeals.

The **Chairman**. You note you brought your budget officer. You're fortunate that your budget doesn't have to go through the OMB. Is that correct?

Judge **Kramer**. Thanks to your wisdom, yes, that is correct.

The **Chairman**. I think, when we drew this legislation up, it took a long time, but it seems we have taken what we thought the good points were and what we thought would make it much easier on your court. I've been very pleased, as I think most people have, that you are a functioning court, hearing the cases of veterans at the highest level, and I hope we can keep it like that.

The gentleman from Florida.

Mr. **Bilirakis**. Thank you. Well, I, too, would like to welcome Judge Farley and Judge Kramer, and Ken, it's good to see you.

Judge **Kramer**. It's good to see you.

Mr. **Bilirakis**. It's good to see that this is what you're doing up here. Ken, you made the comment earlier about judicial review. Knowing the intent of the Congress and of this committee on the passage of that legislation, you led me to believe that it wasn't working. Is it working?

Judge **Kramer**. No, I hope I didn't leave that impression. I do believe it is working.

Mr. **Bilirakis**. All right.

Judge **Kramer**. But like any new entity, you know, it's an evolving situation. It has growing pains and unanticipated problems that one might not necessarily be able to envision without a perspective looking back over time. What I wanted to bring to the committee's attention was just one area that we saw that was developing that perhaps was not anticipated, and that was the area of unrepresented veterans. It's not to say that those cases are not being dealt with, they are, and, we believe, hopefully fairly and equitably and with the right result.

But it does make it more difficult for a veteran to, you know, to advocate his case in a court of law that has some, as much as we have simplified them, has some technical rules and requirements, especially when the proceeding has become an adversarial one.

This veteran is used to a process within the Department that at least is theoretically non-adversarial. In other words, it's one in which the Department is obligated to assist the veteran and to help him or her to develop evidence and facts necessary to adjudicate a claim.

Once that case leaves the Department, and that veteran is unsatisfied with that result and has decided to seek judicial review in our court, that process that I've described, which for years has been one of sort of stewardship for the veteran, all of a sudden becomes an adversarial process, where it is, in effect, Department against veteran, as is true in a typical court situation.

The Department has built a very formidable legal entity. I'm not sure what their current numbers are, but I would say in round numbers, something in the neighborhood of 25 to 30 attorneys, plus staff, to in effect represent the Department and its interests in front of the Court. Once that case comes to our court, the Department is, in effect, trying to defeat the appellant's claim, or at least that part of the claim which is being appealed. This is something that the appellant is not used to in the typical Departmental setting.

Mr. **Bilirakis**. So you feel there is an imbalance there, apparently?

Judge **Kramer**. Well, there is that potential.

Mr. **Bilirakis**. There is.

Judge **Kramer**. And we are doing the best we can, I think, to recognize that, but, on the other hand, what I have learned being a judge—I don't learn much, but I try to learn something along the way—this is something that you learn based on your new experiences, is that a court should be impartial. In the optimal sense, it ought not to advocate for any particular side. It ought to, in a completely neutral way, evaluate the merits of the presentations of both sides.

But neutral evaluation of presentations won't do justice for many of our appellants who have minimal educational levels; are from an economic perspective, dependent upon whatever the Department is providing them in benefits for most of their sustenance; and who are not sophisticated people.

Mr. **BILIRAKIS**. So in other words, when we say judicial review, it may not necessarily, then, be a true judicial review in view of the fact that, in many cases, they just don't present their case as adequately as ordinarily one might expect.

Judge **KRAMER**. Well, I would say that they're at some disadvantage, and therefore it is incumbent upon the court to probably take that extra step and go that extra mile, but it puts us on the somewhat dangerous ground of becoming advocates to do that, to ensure that they're getting the judicial review that they're entitled to.

I think the chairman's observation was very correct that several of our service organizations are—one in particular, are taking the lion's share of the load in representing people in front of the court, but it still is not enough.

We have a bar of attorneys now of approximately, I would guess, somewhere in the neighborhood of 250 to 300 members of the Bar, probably closer to 250. We only have about 14 or 15 non-attorney practitioners in front of the court. This committee in its enabling legislation asked the court to consider carrying on the practice of admitting non-attorney practitioners as it had existed at the Department, something the court provided for in its rules.

These 14 or 15 non-attorney practitioners take on a very high percentage of the case load. But added together with lawyer members of the Bar, still, that only accounts for one-third of the cases.

Mr. **BILIRAKIS**. All right. Thank you. I know my time is up. I thank the gentleman.

The **CHAIRMAN**. Thank you. I recognize the gentleman from Kansas, who has been on this committee for a number of years. He was on the budget committee, and he had to take a leave of absence. We're glad to have Mr. Slattery from Kansas back on the committee.

Mr. **SLATTERY**. Thank you, Mr. Chairman. Ken, good to see you again.

Judge **KRAMER**. Good to see you.

Mr. **SLATTERY**. I'm glad to see that life after Congress is treating you well. I just had one very brief question. I'm just curious—of the cases that you all have dealt with so far, how many reversals of lower judicial hearings have been reversed?

Judge **KRAMER**. I can provide that number for the record. I would say for those that get past the summary disposition—in other words, there are a number of cases that, based on our legislation, the court does not have jurisdiction over because the dates and the time frames may not be correct. In particular, they may have filed an appeal beyond the 120 days that the legislation provided, or, I think even more acutely, their Notice of Disagreement, which is the triggering document for our jurisdictional in many cases, are filed before the date of enactment of our enabling legislation, and that precludes us from jurisdiction. So a number of those cases are dealt with summarily because the court does not have jurisdiction.

Once you get by those kinds of cases, I would say a reasonably high percentage. I will have to go back, and we will provide that.

The CHAIRMAN. Just give us a guess. You know, we wait on you bringing it up here for the record.

Judge KRAMER. I would guess 25 percent, would be my guess. I do not know whether Judge Farley would concur in that.

The CHAIRMAN. Judge Farley?

Judge KRAMER. Twenty-five to 30 percent, I would say, are being reversed, of those that are not summarily disposed of, for jurisdiction issues.

Judge FARLEY. That is right. Let me describe the summary disposition process. The way we took the authority you gave us is to use a single judge as a screening judge. The issue in most cases is factual and the standard of review is clearly erroneous. So, if there is a basis in the record for what the Board of Veterans' Appeals decided, we have no choice. We must affirm the BVA decision. Thus, we use a screening judge to look at both jurisdiction and the possibility of summary disposition. Of cases resolved by summary disposition, maybe 25 percent are reversed. It might not even be that high.

With respect to cases in which we write full opinions, and I think we are up to 40 such opinions, I think the reversal or the remand rate is considerably higher. I would guess it might be about 75 percent.

Mr. SLATTERY. I want to make sure I understand the terms that you are using and exactly what they mean, I guess. So after you determine that you have jurisdiction, then what is the next step on that? Explain the summary process.

Judge FARLEY. The single-judge review to determine jurisdiction and the possibility of summary disposition occurs at the same time.

Mr. SLATTERY. Okay.

Judge FARLEY. The case gets worked up. The briefs come in, or there may be a motion by the Secretary raising a jurisdictional challenge because the veteran cannot meet one of the time requirements.

Mr. SLATTERY. Okay. So there are two threshold questions. One is jurisdiction. The next decision that has to be made is whether summary judgment should be given?

Judge FARLEY. That is correct. Exactly. Just like a district court proceeding.

Mr. SLATTERY. What percentage roughly—and I do not want to hold you all just to precisely—but what percentage do you dispose of on a summary basis?

Judge FARLEY. I would say probably 70, 75 percent.

Mr. SLATTERY. Okay. So just going through the funnel, then, as you look at this, what percentage that hits you are dealt with or dismissed because of jurisdictional reasons?

Judge **Farley**. I would probably say 25 percent of those are jurisdictionally defective.

Mr. **Slattery**. Twenty-five percent are dismissed for jurisdictional reasons, and then the next threshold is the summary judgment issue, and then you say how many there, 70 percent?

Judge **Farley**. I would guess that figure, yes.

Mr. **Slattery**. So then 70 percent of what is left are dismissed on, or dealt with on a summary basis, and then what is left, you are saying, what was it again?

Judge **Farley**. If a case is not resolved by summary disposition, it would go to a three-judge panel and either be conferenced, or there would be an oral argument held.

Mr. **Slattery**. Right.

Judge **Farley**. After the conference or hearing, an opinion would come down. There have been 40 opinions, 40 full opinions, I think, to date. My guess is that we reversed or remanded almost three-quarters of those.

Mr. **Slattery**. Oh, really?

Judge **Farley**. In so doing, we have given, we hope, a lot of guidance to the Board of Veterans' Appeals.

Mr. **Slattery**. Your view, and Ken, I would just like to hear your view on this also, is that by merely defining the law more precisely in this process, perhaps we are going to see more justice done with the Board process, up to your point. Is that accurate?

Judge **Farley**. That is our hope. Yes, very much; that is our hope.

Mr. **Slattery**. Okay.

Judge **Farley**. In essence, what I guess we are saying, Congressman, is that a decision in one case can affect hundreds in the future.

Mr. **Slattery**. Absolutely. Yes. Okay. Well, my time has already expired, and this chairman runs a tight ship around here. So I am going to cease any further questioning.

The **Chairman**. No, go ahead, Jim.

Mr. **Slattery**. No, that's fine. Thank you.

The **Chairman**. If there are no further questions, then I want to thank the last two members here for seeing it through, and also thank our Judges for their patience.

The committee now stands adjourned until 9:30 in the morning.

[Whereupon, at 11:50 am., the committee recessed, to reconvene at 9:30 am. the following day, Thursday, February 21, 1991.]

FY 1992 BUDGET FOR VETERANS BENEFITS AND SERVICES

THURSDAY, FEBRUARY 21, 1991

House of Representatives,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to notice, at 9:30 am., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery, (chairman of the committee) presiding.

Present: Representatives Mr. Edwards of California, (vice chairman), Mr. Applegate, Mr. Evans, Mr. Penny, Dr. Rowland, Mr. Slattery, Mr. Harris, Mr. Kennedy, Mrs. Patterson, Mr. Sangmeister, Mr. Jones, Dr. Long, Mr. Peterson, Mr. Edwards of Texas, Ms. Waters, Mr. Brewster, Mr. Geren, Mr. Stump, Mr. Burton, Mr. James, Mr. Paxon, Mr. Spence, Mr. Nichols and Mr. Santorum.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The Chairman. The committee will come to order.

This is the second day of our hearings on the Administration's, 1992 budget. Yesterday we heard from the Secretary of Veterans Affairs, the Assistant Secretary for Veterans Employment and Training, and Judges Ken Kramer and John Farley with the U.S. Court of Veterans Appeals.

This morning we will hear from our colleague, Jim Jontz from Indiana and we'll welcome him—he's a former member of the committee—and Ben Gilman, a very close friend of ours from New York and he's always very supportive of our veterans' bills as well as Jim Jontz.

We will hear from representatives of the VFW, DAV, AMVETS and PVA. The four veterans' organizations will deliver their Independent Budget and I might say it's been helpful to us, to members of the committee; the VFW, DAV, AMVETS and PVA pitch in together and come up with an Independent Budget. We can compare that budget with the President's submission and it works very well for us. It helps us.

Following their testimony, we will hear from a panel consisting of Dr. Kenneth Shine, Dean of the UCLA School of Medicine, Dr. Wendell Musser, Chief of Staff, VA Medical Center, Atlanta, GA and Dr. Daniel Winship, Dean of the Medical School at Loyola University of Chicago.

Our final panel will be representatives of the American Legion, Non Commissioned Officers Association, and Vietnam Veterans of America.

Now I would like to recognize my good friend Bob Stump, ranking minority member.

Mr. STUMP. Thank you, Mr. Chairman. I'd just like to welcome you back, Jim, to the committee, and Ben, we're glad to have you here and look forward to your testimony.

The CHAIRMAN. Ben, since you outrank Jim, we will let you go ahead and I want to say Ben had a hip operation about 2 months ago, and is making a full recovery and notice you're just using a light cane now, so we wish you the best.

STATEMENT OF HON. BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. GILMAN. Thank you, Mr. Chairman and thank you, ranking minority member Mr. Stump and the distinguished members of the committee for conducting a hearing on such an important issue as our veterans' budget for the coming fiscal year.

In early January, January 3, as a matter of fact, our first day of the new session, I introduced H.R. 103, legislation to boost funeral benefits to a level that had been previously afforded to all of our veterans.

Prior to 1981 as you know a burial allowance of up to $300 had been provided in all cases where a veteran passed away, first of service-connected disability, and second, if he or she was a veteran of any war, and third, if he or she were discharged for a disability incurred or aggravated in the line of duty, or fourth, they were in receipt of or entitled to disability compensation.

Under the Omnibus Reconciliation Act of 1981 unfortunately the veterans burial benefits were decreased significantly by limiting funeral benefits to veterans receiving pensions or compensation or residing in a supported health facility at the time of death. That reduction mistakenly placed an economic value on a benefit given by Congress to ensure that all veterans would be buried with dignity and respect regardless of their income or social standing at the time of death.

It is also in direct violation of a long-standing principle held by the American Legion which calls for equal benefits for equal service.

The 1990 Omnibus Reconciliation Act further limited burial plot allowances. The 1990 Veterans' Benefits and Services Reconciliation Conference Agreement eliminated the plot allowance of $150 with the exception of veterans who are in receipt of DVA disability benefits such as compensation or pension.

My legislation would restore the pre-1981 eligibility for veterans for the purposes of receiving funeral benefits. It increases the amount of those benefits from $300 to $400, not a major increase. It increases the plot allowance from $150 to $300, probably still not enough to take care of most of the plot expenses.

Mr. Chairman, the death of a loved one as we all know is an emotional strain on any family and should not be a financial strain as well. In these times the cost of a burial has increased dramatically, often becoming a tremendous financial burden on the families of veterans during their time of grief.

It is my sincere hope that this legislation would help defray a portion of those burdensome costs. As the fighting in the Gulf continues to escalate, we have to realistically expect that the number of casualties may increase. No one likes to think about the possibility of death and our service members and their families have enough to worry about in these times. They shouldn't have to worry about having to pay for a funeral as well.

I think that we all have a moral obligation to restore these benefits that we promised to our Nation's veterans at the time of their induction into the service of their Nation to provide them with reasonable compensation for funeral costs.

Reinstating these deserved benefits to our veterans I think is essential to fulfill our obligation to all those who fought and risked their lives to protect the ideals and the people of our great Nation, so permit me once again, Mr. Chairman and distinguished members, to express my appreciation to your committee for the opportunity to bring this issue before you today.

[The prepared statement of Congressman Gilman appears on p. 217.]

The CHAIRMAN. Thank you very much, Ben Gilman, and we'll go to Jim Jontz and then if any members have any questions for you, Ben, we'll come back to you.

Mr. JONTZ.

STATEMENT OF HON. JIM JONTZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. JONTZ. I thank you, Mr. Chairman, Mr. Stump, members of the committee. This is my first opportunity to appear before you in this capacity, as a witness, and I want to take advantage of that opportunity, first of all, to say thanks to the committee and the staff for assistance during the time that I was a member of this committee, and secondly, as an opportunity for me to demonstrate that I learned that brevity is of great importance to this committee in its proceedings, so I will be brief this morning.

Let me first note one item in the construction budget that has come before this committee before, and that item is proposed funds for the construction of a new 240-bed geropsychiatric unit at the Marion VA facility in Marion, IN. This committee recommended funding for fiscal year 1990 for the design phase of that project which has been completed. The VA is now requesting $45.8 million for the construction of this facility which is very much needed to bring the Marion VA up to date, and I would respectfully request the continued support by this committee for that expenditure.

For the balance of my testimony this morning, I want to address needs which regrettably I do not see adequately dealt with in the VA's proposed budget, specifically in the area of Post-Traumatic Stress Disorder.

This committee last year approved legislation which was later approved by the House, but regrettably was not taken up in the Senate, to significantly expand what our Nation is doing to meet the needs of our veterans who are still dealing with readjustment problems and currently suffering from Post-Traumatic Stress Disorder.

Regrettably the VA's budget for this coming year does nothing beyond the accounting for inflation to expand these services. It would continue the existing 20 inpatient units and 44 clinical teams, as well as the operation of the National Center on PTSD and the 195 Vet Centers, but would not in any way expand that network.

This is regrettable given that the VA's own study as of 2 years ago indicated some 400,000 Vietnam veterans who are currently suffering from PTSD but who are not getting help from the VA. This is the 7th year that the VA has ignored its own Special Committee on PTSD's recommendations for expanding PTSD programs. At some future date I am hopeful that I might have the opportunity to testify before the Hospitals and Health Care Subcommittee with regard to H.R. 841, which is the revised version of the PTSD legislation from last year, which I have resubmitted. A number of you are co-sponsors of that bill, and your support is appreciated.

My hope is that for the purposes of budget recommendations, this committee will recommend some additional funding so that we can begin the important task of meeting the needs which exist with regard to treatment for PTSD.

The fact that there are now hostilities going on in the Persian Gulf make the needs even greater. The incidence of Vietnam veterans with PTSD is increasing dramatically because of their exposure to coverage of combat in the Gulf, and of course it is likely that there will be veterans returning from the Middle East who will also need these services.

The Independent Budget did recommend an additional $7.25 million. I would propose that the committee consider a minimum increase of $12.5 million for PTSD treatment which would implement the first year of H.R. 841 as proposed, adding 15 new clinical teams, 5 new inpatient units, 5 new Vet Centers and a halfway house.

Mr. Chairman, I know that this committee understands very well the obligations we have to veterans of previous wars as well as to veterans who will be coming home soon from the Persian Gulf. To meet these needs—in my opinion dealing with PTSD for the veterans who return is just as much a cost of the war as the cost of the weapons that we are sending them into battle with—I know this committee will do everything it can within the limitations that you must work with to see that these needs are met.

Thank you very much.

[The prepared statement of Congressman Jontz appears on p. 212.]

The CHAIRMAN. Thank you, Jim, thank you Ben. Certainly we will look at both of these areas that you touched on. As you know, we do have the Budget Enforcement Act limitations now. You know the committee is bound by the pay as you go provision. Of course, members can offer amendments and proceed however they would like to. Three or four of the bills we have brought to the floor this session have been challenged by the Budget Committee, because the bills didn't say where the funding was coming from. So that is a problem.

I will not call on each individual member, but if any member would like to ask—comment or question to Ben.

The gentleman from Indiana.

Mr. **Burton**. If my figuring is correct, you are asking for $5 million more approximately for the centers that you are talking about, right?

Mr. **Jontz**. The Independent Budget which you will hear presented in testimony later this morning, recommends seven and a half million dollars additional for PTSD. This recommendation, I feel certain, was based on what was the first year's cost for implementation of the legislation as we wrote it last year. In rewriting the legislation for this year, we have front-loaded the legislation somewhat. The goal would still be the same, of adding 30 inpatient units, 40 vet centers and 50 clinical teams. But we have front-loaded those a little bit, recognizing that the needs are more critical now than what we anticipated they would be a year ago.

So, my recommendation to the committee is to fund the first year of the legislation H.R. 841, which would be 12 and a half million dollars, at least as we calculate at this point.

Mr. **Burton**. So, it is about five million above the recommendation?

Mr. **Jontz**. From the Independent Budget, not from the VA's budget. The VA recommended no increase for new services. They only recommended.

Mr. **Burton**. So this was 12 million and above——

Mr. **Jontz**. 12 and a half million. Yes, sir.

Mr. **Burton**. Okay. The second question I have, Mr. Chairman, is these facilities that you are advocating we put in place were not picked out of the sky. Who gave you the indication that the facilities you were talking about would be adequate?

Mr. **Jontz**. Well, we do not know that this expansion will be adequate. But this expansion is consistent with the recommendation of the VA's own Special Committee on PTSD, which for 7 years has recommended that the VA have an inpatient unit in each state and has also recommended that there be a PCT for each medical center that provides mental health services. It has also recognized the need to do more to expand the capacity of Vet Center program to meet the needs of veterans who are not now being met.

So, our recommendations are very consistent with the VA's own Special Committee on PTSD which they have consistently ignored.

Mr. **Burton**. Thank you very much. Thank you, Mr. Chairman.

The **Chairman**. Mr. Applegate.

Mr. **Applegate**. Thank you, Mr. Chairman. Again, I say, Jim, it is good to see you come back to the committee and we will be looking for big things from you where you are and, of course, it is always good to see Ben Gilman because he is here every year with something pushing for the veterans and he is really one of their champions.

I was just going to say that we had taken steps to try to make some reductions in that burial allowance last year, and—and try to stay within the confines of what this committee's authorization was supposed to be, and we did that. We did that.

Even with Jim's proposition last year. I think it could have been maintained, so that there was no additional spending that we had to worry about. However, you know, the—when the President brought forth his budget this year, he brought forth a budget that was some $60 billion or more in deficit, above the last years. Where is he going to get the money? I mean, does he still have to maintain the same constraints that we do in the Congress, or what? I mean, it seems to me that he should be—he is going to have to—he should, if he is going to stay within the law that we passed, find new taxes to make up for the $60 billion, because we should be maintaining no more than what we passed in deficit last year. Am I correct, or am I not correct? Which I think was what—about $260 billion; is that what it ended up last year?

Mr. **Jontz**. [Nods yes.]

Mr. **Applegate**. So, now we are at $318 billion. So there is an increase.

Now, if the President of the United States is going to—is going to go beyond the law, as we have passed it, then I do not see why each of the individual members with theirs should not do the same thing.

What Ben Gilman is talking about is increasing this burial allowance, and I do not know what kind of cost—what kind of cost did you say there was involved, Ben?

Mr. **Gilman**. Well, we do not have any estimates, of course. It would be determined on how many casualties we might have and that sort of thing, which would be open ended. There is no way, at the moment, I do not think, of getting some accurate estimates.

Mr. **Applegate**. But you are talking in terms of millions, not billions?

Mr. **Gilman**. Millions. It would be—it is not a substantial increase that I have suggested. As you know, 300 from 150 for plot allowances——

Mr. **Applegate**. Yes.

Mr. **Gilman** [continuing]. Which doubles the plot with only 400—over 300 original costs for burial benefit.

The **Chairman**. Would the gentleman yield?

Mr. **Applegate**. Yes.

The **Chairman**. As I understand it, under the Reconciliation Act that was passed for this next fiscal year 1992, it did permit the President, on discretionary funding, to go up 6 percent. I pointed out, yesterday, that the budget they submitted to us was only 4.6 percent increase for veterans programs. So, I think that makes up the difference of the $60 billion that you mentioned for all discretionary approvals.

Mr. **Applegate**. Are we also allowed to go up 6 percent?

The **Chairman**. The budget they sent up was 4.6 percent and, I guess it is—I guess the Budget Committee can make the changes, if they let us go up to 6 percent.

Mr. **Applegate**. Because it seems to me that——

The **Chairman**. Maybe Jim Slattery could help us out. He just came off the Budget Committee.

Mr. **Slattery**. Mr. Chairman, I do not know that I can add much to the discussion, other than to observe that within the discretionary cap that the Budget Committee has to work with, the Budget Committee can make some adjustments. So, for example, if the Budget Committee would decide that we are going to spend less for the super collider, for example, we could shuffle some money over to Veterans Affairs. If we decided and the Budget Committee decides in its wisdom, to reduce the allocation for space, for example, it would make some additional funds available for veterans benefits. So, within the discretionary cap, the Budget Committee and the Congress has latitude to make adjustments. I hope that we will do that as the year proceeds.

The **Chairman**. Are you talking about more or less latitude, where you can just sort of move it from one program to another?

Mr. **Slattery**. Within the discretionary cap pool, we can move money from function to function.

The **Chairman**. Yes.

Mr. **Slattery**. What we are restricted to is the overall cap for the discretionary spending pool. So, we have significant latitude within that pool to make the adjustments that we need. So I think that, as this committee does its work, I hope that we will do so in the context of realizing that we might have some legal room here, depending on what the Budget Committee does.

The **Chairman**. Are you through?

Mr. **Applegate**. No.

Mr. **Rowland**. I just wanted to ask a question.

Mr. **Applegate**. Did you want me to yield to you?

Mr. **Rowland**. No, would the gentleman yield to ask a question of Mr. Slattery?

Mr. **Applegate**. Sure. Go ahead.

Mr. **Rowland**. Can you move from one function to another function, or is there some restriction on what you can do?

Mr. **Slattery**. There is restriction that you cannot move, for example, money from the Defense cap pool to the discretionary pool. If you are going to move money or, for example, if you reduce the amount of money we spend on defense, that reduction has to be applied to the deficit; it cannot be moved from function to function, unless, of course, the Congress and the President would agree to do that. You cannot move from pool to pool in effect. You can make adjustments within the pool.

Mr. **Applegate**. Well, I was just going to say that I suppose the philosophical direction of this is the fact that you are looking at trying to balance the budget as best you can, and it seems like that they should stay within the limits of the law. If you want to balance the budget, why, you should not be extending beyond it. Nevertheless, that is an argument for a different time.

In that respect, it seems to me that we should be taking care of the veterans as best as we possibly can and I think that Ben has pointed out very succinctly as to the needs and who it is going to affect most. As far as the veterans concern, I see nothing wrong with it, and the amount of money.

As far as Jim Jontz is concerned, I had mentioned yesterday the fact that his proposal for post-traumatic stress disorder and the needs because of the—even though they, and God help us if they do and we pray that they will not haver to go into land battle, they still are going to suffer that stress, and they are still going to need the counseling services. I do not think that that is adequate as it is now. The fact that there is an incidence with the Vietnam veterans today because of the peculiar situation that they were in during their period of service, that they are going to need it. We did have that amount of money.

It seems to me that the Halfway House Proposal that you had talked about—I think these are necessary. Of all the legislation that we saw that has been introduced in the last couple of weeks by so many of the members, that these are the directions that we ought to be taking. They are minimal cost for the greatest need. I think that we should seriously take a look at that. The amount of money that we may go on beyond, I think, is very very small.

So, that is my own ideas on it.

The CHAIRMAN. The gentleman from Pennsylvania, a new member of the committee.

Mr. SANTORUM. Thank you, Mr. Chairman.

I just wanted to clarify Mr. Applegate's point about the President's budget being over by $60 billion. That really is not the case. He came in within the reconciliation targets.

The reason that we have a higher deficit is due to the fact of entitlement programs being higher; they are not subject to budgetary caps; also, other off-budget items that came in, like the savings and loan and other types of costs, increased, and the reconciliation bill does nothing to limit deficits.

It just limits spending and puts on spending caps. So, the deficit can actually fluctuate, and that is the reason the budget came over by $60 billion from last year.

The CHAIRMAN. If there are no further comments, we want to thank our witnesses and Members of the Congress for being here. Thank you very much.

Mr. JONTZ. Thank you.

Mr. GILMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Now, we will have the Independent Budget panel—Mr. Larry Rivers, Executive Director of the VFW; Mr. Jesse Brown, Executive Director of the Washington Office, Disabled American Veterans; Mr. Robert Jones, National Executive Director, and Mr. Woosley of AMVETS; and Mr. John Bollinger, Associate Legislative Director, Paralyzed Veterans of America.

We would like for you to keep within the 5-minute limitation so members can make comments or ask questions, and whoever would like to start off testifying, the Chair would recognize how you would like to do it.

Larry, you look ready. So, you go ahead. Larry Rivers, VFW.

STATEMENTS OF LARRY W. RIVERS, EXECUTIVE DIRECTOR, VETERANS OF FOREIGN WARS; JESSE BROWN, EXECUTIVE DIRECTOR, WASHINGTON OFFICE, DISABLED AMERICAN VETERANS; ROBERT L. JONES, NATIONAL EXECUTIVE DIRECTOR, ACCOMPANIED BY NOEL WOOSLEY, NATIONAL SERVICE DIRECTOR, AMVETS; JOHN BOLLINGER, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF LARRY W. RIVERS

Mr. RIVERS. Mr. Chairman, I am the chairman for the Independent Budget Committee this year. Thank you very much.

It is a pleasure for us to be here before this very distinguished group once again, and thank you very much for having us.

Mr. Chairman, this is the 5th year that we four veterans' service organizations have come together to formulate and present to the

Congress our independent assessment of veterans needs and a responsible budget to meet those needs through programs administered by the Department of Veterans Affairs.

Our organizations represent approximately 3 ½ million veterans, and we are not only concerned with the wellbeing of our members but we are concerned with the wellbeing of all veterans and concerned that all veterans receive health care and all other benefits to which they are entitled.

We do acknowledge and truly appreciate the efforts of those that are on this committee and those within the Department of Veterans Affairs that work so hard to obtain additional essential funding necessary to manage the VA programs and to provide veterans with needed health care.

The billion-dollar increase for medical care last fiscal year and the proposed billion-dollar increase this fiscal year are, indeed, significant. However, we would point out that these increases barely cover the costs of medical-care inflation and do nothing to solve the serious problem in the delivery of other benefit programs. Those increases remain insufficient to maintain a now seriously-eroded base of available medical care.

We acknowledge that these are times of severe budget austerity. Therefore, our proposals are realistic and responsible, given the obligation of the Federal Government, and meet the needs of veterans through programs promised and established for them.

This year we have taken a different approach in the benefits section. We proposed a repeal of the Omnibus Budget Reconciliation Act of 1990, the veterans entitlement restrictions.

In support of that, we recommend far less painful savings of sufficient magnitude to meet Omnibus Reconciliation Act savings plus suggestions to provide financial relief for VA as a whole.

The problems of service to veterans will not be solved until the Omnibus Budget Reconciliation Act nor with the proposed fiscal year 1992 budget.

We believe it will be necessary to take action such as we recommend in the Independent Budget to stem the tide that is seriously eroding all veterans entitlement programs.

The service and benefit shortfalls resulting from inadequate funding which we predict in this and prior independent budgets have been uncannily correct.

For this reason alone, if for no other, no one can truthfully say that veterans are only looking for more or that they are never satisfied. Our satisfaction will be evident when the Federal budget programs are corrected to meet the Nation's commitment to those who serve.

Veterans have become weary of constantly being told that the Federal funding is increasingly austere and that requirements of other budget accounts are as valid as veterans programs.

Today, thousands of young Americans are being asked to match the sacrifice of the millions of veterans who served in defense of this Nation before them.

Now, more than ever, we believe it is essential that our Government maintain the quality and quantity of veterans benefits and service through top-priority funding equal to if not greater than provided other Federally-sponsored programs.

If we are first during time of war, we should likewise be first in times of peace.

As a grateful Nation, we must live up to our President's State of the Union words about the servicemen and women in the Persian Gulf, and I quote.

"Our commitment must be the equal of their commitment to their country. They are truly America's finest."

That applies, as well, to those who have served before them.

At this time, Mr. Chairman, I would ask Mr. Robert Jones, the Executive Director of AMVETS, to discuss the cemetery portion of our Independent Budget.

[The prepared statement of Mr. Rivers appears on p. 227.]

The CHAIRMAN. Thank you, Larry.

STATEMENT OF ROBERT L. JONES, NATIONAL EXECUTIVE DIRECTOR, ACCOMPANIED BY NOEL WOOSLEY, NATIONAL SERVICE DIRECTOR, AMVETS

Mr. ROBERT L. JONES. Mr. Chairman, thank you for the opportunity to appear today to discuss the Veterans Affairs fiscal year 1992 budget.

With your permission, I request that my written testimony be entered into the record.

In prior independent budgets, the veterans' service organizations have been complimentary concerning the National Cemetery's staff's managerial capabilities. We continue to be impressed with the dedicated staff's capability to do more with less.

Interment and grave site maintenance workloads have increased substantially. Staffing and equipment repair or replacement has not kept pace with demands on the system, and approximately 20 cemeteries are projected to close between fiscal year 1991 and 2000.

The 1991 amount appropriated for the National Cemetery Service was $1.2 million less than the original request. This resulted in reducing the planned staffing by 38 staff with consequent negative effects on cemetery operations and maintenance. Funding for maintenance and repair projects was also reduced. There was a total shortfall of approximately $16 million in the 1991 budget of the National Cemetery Service.

Consistent with the Independent Budget recommendations, both the House and Senate recommended significant increases over the VA's appropriation request. After the appropriations process was completed, the National Cemetery Service received $53 million, or $1.3 million less than requested by the VA, and $16 million less than recommended by the Veterans' Affairs Committees.

Regardless of how efficiently managed or how capable of a staff is maintained, there are limits to the ability to stretch resources to fulfill demand. Cracks are now beginning to appear in the capabilities of the National Cemetery Service to maintain its heretofore excellent standards.

An example is the Riverside, California National Cemetery, where recently disgusted veterans have complained about sunken graves, unaligned grave markers, and large, muddy areas that are marred by vehicle tracks.

Now, I am sure that this situation resulted from a combination of circumstances, and generally does not reflect the overall conditions of our National Cemetery system. But I am equally certain that the situation at Riverside reflects the result of a system grappling with continuing general fiscal restraints.

The Congress must act to preserve our national cemeteries, which are akin to our national memorials, and therefore should be considered a national treasure. The Independent Budget recognizes that there is a $2.1 million shortfall in deferred maintenance and repair. And we recommend that the Congress maintain the fiscal year 1991 appropriated level in the 1992 budget and provide revenues needed for items highlighted in the House Veterans' Affairs fiscal year 1991 budget report. We also suggest that funding be provided to remedy the shortfall in deferred maintenance and repair.

There is a dire need, Mr. Chairman, for an appropriation of at least $71.9 million, an increase of $18.4 million over the fiscal year 1991 appropriation level to restore and maintain the National Cemetery Service to acceptable levels.

Mr. Chairman, this concludes my statement, and with your permission, I would like to yield my time to my colleagues.

[The prepared statement of Mr. Jones appears on p. 252.]

The CHAIRMAN. Thank you.

Mr. RIVERS. Mr. Chairman, the benefits and GOE portion of our Independent Budget was handled this year by the DAV. We ask Mr. Jesse Brown, the Executive Director of the Disabled American Veterans for that overview, sir.

The CHAIRMAN. Okay. Jesse.

STATEMENT OF JESSE BROWN, EXECUTIVE DIRECTOR, WASHINGTON OFFICE, DISABLED AMERICAN VETERANS

Mr. BROWN. Thank you. Thank you, Larry.

Mr. Chairman and members of the committee, I am pleased to have this opportunity to present our views on the budget request of the Department of Veterans Affairs for budget year 1992.

Mr. Chairman, in his State of the Union Address, the President spoke most eloquently about the hard work of freedom. He said, and with your permission may I quote: "We are Americans. We have a unique responsibility to do the hard work of freedom." He paid a moving tribute to our troops in the Persian Gulf, stating "The conviction and courage we see in the Gulf today is simply the American character in action," and it is the same spirit that gives us the power and the potential to meet our toughest challenges at home.

The President also said, "We are resolute and resourceful. If we can confront evil for the sake of good in a land so far away, then surely we can make this land all that it should be."

Mr. Chairman, American veterans, more than anyone else, have done "the hard work of freedom," as our troops are now doing in the Persian Gulf. Surely the first order of business in "making this land all that it should be," must be to honor the commitment to those who have done "the hard work of freedom."

Sadly, there is a growing concern that this is not the case. We can reach no other conclusion, after analyzing the omnibus Budget

Reconciliation Act of 1990 and the VA's 1992 budget request. Any discussion of the VA's 1992 budget request must begin with an analysis of OBRA. The DAV prepared the benefit programs and general operating expense portions of the Independent Budget. Both of these were adversely affected by OBRA.

Mr. Chairman, the VSOs have repeatedly stated that veterans are willing to do their fair share in reducing the deficit, despite the sacrifices they have already made in doing "the hard work of freedom."

However, we fully expected that other programs would do their share, and that the full array of Federal grants and pork barrel projects would be stripped to the bone, if not eliminated. These, in our view, were not unreasonable expectations.

You can appreciate our shock to discover, after examining the over 1,200 pages of the OBRA Conference Report, that veterans entitlement programs had been singled out for deficit reduction. Other programs, like Social Security, not only escaped cuts, they have been enhanced. The Independent Budget, and my written testimony, analyze this basic unfairness of these entitlement cuts in detail, but I would like to take this opportunity to give you some examples of how service-connected veterans have been singled out to bear the burden of deficit reduction.

Compensation and DIC recipients alone had a COLA delay to achieve savings of $49 million. The same provision applied to non-need-based Social Security benefits would have saved $980 million.

OBRA imposes a means test on certain incompetent service-connected veterans to achieve savings of $291 million in 1991 and 1992. No such test has been imposed on other non-need-based Federal programs.

There are 28 times more payees who receive non-need-based benefits on behalf of incompetent Social Security beneficiaries and fiduciaries who receive compensation on behalf of incompetent veterans. Think of the savings if this provision were applied to Social Security.

The list goes on. Only the widows of veterans who died of service-connected disability lose eligibility for benefits forever, if they remarry, regardless of their age or financial circumstances. Only service-connected disabled veterans lose eligibility to vocational rehabilitation service.

Mr. Chairman, the point, in our view, is clear. OBRA entitlement cuts unfairly single out veterans. In preparing the 1991 Independent Budget, I think the VSOs have displayed the spirit that characterizes veterans and to which the President alluded in his State of the Union Address. The VSOs have developed a deficit reduction plan that exceeds OBRA's 5-year deficit reduction targets by $2.4 billion, without entitlement cuts. These savings should be retained and used by VA to improve veterans health care, benefits, and service delivery. Implementation of the plan requires, of course, legislation. I therefore urge this committee to review the plan, which is fully described in the Independent Budget. I am confident that you will agree that the VSO's deficit reduction plan is a better and fairer way to achieve deficit reduction.

Mr. Chairman, my remarks on the VA's 1991 budget request as it relates to Veterans Benefits Administration will be brief. The committee is aware of VBA's problems. Benefits and service delivery has not improved since this committee issued its thoughtful and detailed report to the Budget Committee on the VA's 1991 budget request.

It is very much like taking the same picture all over again. The 1992 Independent Budget relied extensively on the analysis in that report. What has changed is that VBA has significantly more employees, all of which have been earmarked to implement OBRA deficit reduction provisions. There are no additional employees to provide needed service improvements. In fact, we calculate that in 1992 there will be 267 fewer BVA employees to adjudicate claims, answer veterans calls, conduct outreach programs, service loans, and provide vocational rehabilitation services for veterans.

The VSOs think that it is ironic that the VA has virtually a blank check to add employees funded from the compensation and pension account to implement and enforce deficit reduction entitlement cuts and restrictions which unfairly single out veterans.

At the same time, there are fewer employees to deliver benefits and services to veterans and their dependents. This is the reality of this budget.

When the peace is won, and our troops come home from the Gulf, if they are treated like other veterans, almost, a third of them will not have their compensation claims decided within 6 months. They will have to wait more than 3 months for an interview by a vocational rehabilitation counselor.

Twenty percent of them will not be able to make telephone contact with the Veterans Benefit Counselor. If Persian Gulf veterans are given special treatment as contemplated by the VA, service to veterans of earlier wars will deteriorate further.

The VA's 1992 budget simply ignores these problems. The 1992 Independent Budget recommends an additional 195 FTEE for veterans services and an additional 150 FTEE for loan guarantee so that defaults can be prevented. We also strongly support legislation that would mandate timely adjudication of claims and Vocational Rehabilitation services.

The Veterans Claims Administrative Equity Act of 1991, introduced by Mr. McEwen, does this and we ask the committee's support in seeking its speedy enactment. We are convinced that this is the only way that timely benefits and service delivery will ever be realized.

In closing, Mr. Chairman, I want to say that the VA's 1992 budget request for VA is clearly inadequate. It includes a reduction of 60 FTEE due to so-called workload savings resulting from overt entitlement cuts and a reduction of 125 FTEE due to so-called modernization savings.

It is wrong, in our view, that these FTEEs are not being retained to improve services to veterans. We also propose legislation in the budget request to make permanent the provisions limiting compensation payments to certain incompetent veterans and to further restrict vocational rehabilitation entitlement to the extent that nearly half of those that are on the compensation roles will not qualify for vocational rehabilitation services.

Mr. Chairman, this concludes my testimony.

[The prepared statement of Mr. Brown appears on p. 231.]

The CHAIRMAN. Thank you very much.

Mr. RIVERS. Mr. Chairman, the health care portion of this year's Independent Budget effort was primarily the responsibility of the Paralyzed Veterans of America. Mr. John Bollinger, the Associate Legislative Director will do an overview of that section of our budget.

The CHAIRMAN. You might turn the mike over to him and talk right into the mike, please.

STATEMENT OF JOHN BOLLINGER

Mr. BOLLINGER. Thank you Chairman Montgomery and members of the committee. I'm pleased to present the health care portion of the Independent Budget recommendations for fiscal year 1992 for the Department of Veterans Affairs. If I may, I'd like to submit for the record, a couple of pages which will spare you having to listen to me talk about a whole bunch of numbers.

The CHAIRMAN. Without objection, so ordered.

[The information referred appears on p. 306.]

Mr. BOLLINGER. Thank you, sir. I guess, of all the things VA does, all the services it provides and so on, certainly the provision of health care for sick and disabled veterans has got to be one of the most important things. We can do without a lot of things, but if we can't get decent health care, we're in trouble, both as a Nation and certainly as individuals.

Quality health care truly translates into a quality of life issue for people with disabilities. For some severely disabled veterans, it's more than that; it comes right down to basic survival and it comes right down to being able to count on and being able to rely on the VA health care system.

Although we spoke last year of an obligation to correct budget priorities for veterans, our recommendations were based, in part, on the concern that maybe some had forgotten about the sacrifices that veterans have made. Even yesterday, Secretary Derwinski said that a few years after the war, veterans issues tend to fade away.

The Persian Gulf Crisis coincides with a VA health care funding crisis of enormous dimensions. Again this year, projections of VA funding requirements in the Independent Budget indicate that VA presently does not have the resources to provide the same level of care the Department provided to veterans in 1988.

1988 was the last year that VA's health care system was not severely eroded by grossly inadequate budgets. As a result, VA has been forced to restrict the provision of services to veterans and to reallocate resources from equipment, supplies and other health care support services already in short supply.

Since the first Independent Budget was prepared for fiscal year 1988, we've come before you each year to say the VA health care system is in a state of crisis. To a certain degree, the Administration has seemed to recognize this fact and proposed two consecutive increases of over $900 million each year for fiscal years 1991 and 1992 for health care.

We know that Secretary Derwinski has asked for much more than he received from OMB this year and we're grateful for his efforts. Certainly, the Congress and this committee has greatly improved overall funding by adding approximately $2 billion over the Administration's recommended budgets. Without this, certainly VA's situation would be considerably worse.

Unfortunately, due to the severe damage inflicted by OMB on VA's health care funding levels, especially between 1988 and 1990, coupled with increased geriatric care demand and skyrocketing medical costs, the appropriated amounts have simply not been sufficient to provide an acceptable level of quality medical care services.

Unless funds are appropriated to do more than just keep VA's head above water, disabled veterans will continue to suffer and eventually we may lose a great national resource. During late November 1990, the Independent Budget staff conducted its third annual telephone survey.

We contacted representative VA hospitals across the country and asked them a variety of questions about their hospitals.

Survey questions were designed to elicit information on any continuing impact of budget shortfalls in fiscal year 1990 along with expectations for the current fiscal year.

As I read some of the results of our survey, please keep in mind that this is the VA health-care system, charged with treating not only current eligible veterans but also any potential casualties that may come from the Middle East.

It is a VA health-care system that, according to testimony we heard yesterday, has lost approximately 3,000 health professionals to the reserves.

This is what we found in our survey. In the interest of time, I will read just a few of them, but they are all included in the Independent Budget.

For example, VA medical centers absorbed shortfalls ranging from $1 million to $4 million per facility in fiscal year 1990. To meet the medical-care needs, centers redirected funds originally intended for equipment purchase, contract medical service, personnel salaries, and building maintenance.

Another—most hospitals still report backlogs of needed medical equipment, ranging in total value from $1 million to $8 million per facility. One Chief of Staff estimated that more than $35 million worth of heavily-used equipment would reach obsolescence during the next 5 years, a situation he believed is not uncommon throughout the health-care system.

VA testified yesterday that fiscal year 1992 funding levels will prevent a further increase in the equipment backlog, and quite frankly, Mr. Chairman, with an estimated $1 billion backlog in equipment, we just do not see how that is possible.

Outpatient clinic appointment waiting times of more than three to 4 months were widely reported. Certain specialty clinics had appointment backlogs of up to 9 months to see disabled veterans.

Nursing vacancies existed in every VA facility we contacted. Most hospitals had been 20 and 50 unfilled nursing positions.

Most hospitals reported long delays in scheduling elective surgery. One large tertiary care hospital reported increasing inability to accept transfer patients from referring regional VA centers.

Many of those surveyed reported a growing demand for long-term care and the impossibility of meeting that demand with available resources. There are many more examples, but, in summary, our survey finds that the deficiencies that this committee exposed in special health care hearings in September of 1988, still exist. They have not been corrected.

Another important thing that came out of the survey, is that, to a great degree, unmet needs are still a significant problem throughout the country. Those health-care needs are going unmet as demand is suppressed by resource constraints.

Despite the Administration's increased budget recommendation of $13.3 billion for VA's medical-care account, proposed 1992 funding levels will, at best, only slow down the current funding crisis.

There are numerous unavoidable program and medical-care expenses which will, in actuality, leave the medical-care account with a deficit. As you discussed yesterday, of the $974 million increase, close to $600 million will go to employees salaries, another $280 million to inflation, another $144 million to program changes and other adjustment costs.

So, in essence, nothing will be left to make up the $700 to $800 million shortfalls that have been passed down from previous years. Nothing will be left to reduce the long waiting times and really improve the hands-on patient care for disabled veterans.

All of these are symptoms of an institution that is collapsing under the strain of a mission that will become increasingly impossible to fulfill without enactment of recommendations such as those contained in our Independent Budget.

Our recommendation of $14.8 billion for medical care in fiscal year 1992 is the result of a careful measurement of current service levels and necessary program improvements each year since 1988, and we strongly urge you to adopt these fundings levels.

VA's medical and prosthetics research account also represents one of the most important investments, we believe, of VA funds. This account has been hard hit by insufficient funding over the past 5 years.

Research needs stability. It needs continuity. Researchers must be able to count on appropriate funding levels down the road to maintain ongoing projects and to begin new ones.

The Administration has proposed a budget of $217 million for this important account, with a decrease of 348 personnel in fiscal year 1992. This funding level is approximately $64 million below that which we have recommended and will further erode VA's research capabilities.

The Administration has not included the $20 million transfer from DOD which had been recommended in private budget proposals.

We urge the committee to reject the Administration's budget proposal for the medical and prosthetics research account and instead provide the $280 million necessary to maintain a strong research program.

Please keep in mind that many of the prosthetic devices which are in use today to help individuals overcome wartime disabilities would not have been developed if it were not for the Department of Veterans Affairs.

I know Congressman Montgomery is certainly aware of all the things they have done, and we had a great hearing here a year and a half ago that demonstrated many of the prosthetic devices that VA was responsible for developing, and we certainly appreciate that.

Again, it is clear the VA equipment purchase backlog is a serious liability to the Department, and we certainly urge this committee to do everything you can to resolve that issue in terms of adequate funding.

Finally, the VA's health care system was once a quality system. It does face problems but the problems aren't insurmountable. The Government's investment in VA health care is a good investment. If VA can just get back on track, VA hospitals will once again be able to provide cost-effective, quality health care. If not, this great national resource we have will decline further and disabled veterans will be the ultimate losers. Thank you.

[The prepared statement of Paralyzed Veterans of America w/attachment appears on p. 262.]

The CHAIRMAN. Thank you. We have two other panels. I will recognize members who want to make some comments or want to ask questions. I will reserve my time and recognize any member that would like to say something.

First, let me say this, though: before each member speaks, this is the Independent Budget. It's very well done and we want to thank these four veterans' organizations. They spent some money on this Independent Budget and it's already been mentioned several times today by our—Jim Jontz mentioned about comparison to some areas that he's interested in. Thank you again.

It's getting better all the time, what you're doing, and I hope you continue to do it and I want to thank these four veterans' organizations for doing this. I wish the others would help out.

Mr. RIVERS. Mr. Chairman, if I could just offer one other comment, the last portion was the construction portion. It is outlined in the budget, but because of the time constraints, that was the VFW's area this year with the budget. Because of the time constraints, we would just ask the members if they would look at our budget. There are severe problems in the construction portion of the VA budget as well.

The CHAIRMAN. I agree. Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman. Let me thank you, gentlemen, for your testimony and you and your respective organizations for the work that you have done in participating in the formulation of this Independent Budget. You deserve a lot of credit.

It's comprehensive. It's sophisticated, and as you well know, it carries a lot of weight with this committee when we make our recommendations. But, you know, in the past, it has not been this committee that's been your problem. It's been Budget and Appropriations.

The chairman and I have testified before the Budget Committee, as you well know, and I challenge you and your organizations to do the same. The money is short, and the competition within our own budget allocation is keen, with Housing and EPA and NASA and the other independent agencies all coming out of the same group.

We're going to need your help, and I'd like to know what you're going to do, and if you have plans this year, maybe to lobby those respective committees over there to try to help out.

Mr. **Rivers**. Mr. Stump, I don't think there's any question that we're doing everything we can as far as Appropriations or Budget are concerned. I would probably be less than candid with you if I told you that we were not as familiar with the operations of those committees as we are of our own.

In the past, we have relied on members of this committee to carry the water for us as veterans. Apparently we cannot do that anymore because of the constraints you mentioned. I think I speak for all of us when I say we intend to try as best we can to do a better job to help you with the Appropriations and Budget Committees. We're trying to figure out the most effective ways to do that.

Mr. **Stump**. We look forward to working with you and we're going to be hollering when the time comes to testify before those committees, probably. Thank you.

The **Chairman**. Mr. Applegate.

Mr. **Applegate**. Mr. Chairman, I, too, want to thank you for a very well-thought-out budget as you always present to us. As Mr. Stump said, the problem isn't so much with us as it is with the members of the Budget Committee.

I know that there's been some very severe cuts in veterans programs and in construction which really need to be there. I've said it once, and I'll say it again that while people will say, well, yes, but everybody has to stay within the budget, that that's true. However, if it wasn't for the veterans and the sacrifices that they made, we wouldn't be talking about budgets or deficits or whatever we have. We wouldn't be sitting here as a parliamentary body.

It seems to me that we should and could extend ourselves, if we so desired. To my young friend from Pennsylvania who wanted to try to explain about the budget and the reasons that the President can be allowed to do that, I was trying to make a point. I say again that what's good for the goose is good for the gander and that we should be allowed to increase these programs.

I would only say this to you: Mr. Stump had mentioned about lobbying the members of the Budget Committee, but I would say that between the veterans and the seniors in this country, there's no stronger political forces that we have. We know that the veterans vote; we know that the seniors vote.

When the seniors want something—and they proved that last year on a bill that they said could never be repealed, Catastrophic Illness—the President said he wouldn't change it. Dan Rostenkowski said he wouldn't change it; everybody said they wouldn't change it. It was changed because they went out and got it changed.

This is why I say this to the veterans, because every district has many veterans posts of one type or another and in every one of those posts, those members in there should call those guys into the post and have them—look them in the eye and tell them what they're going to do. I'll guarantee you if you do that, you can do a lot of things.

That's the most solid force that you've got, and you can get that accomplished. You'd be surprised what that can do. So, that's all I would say and I would say, again, thanks for what I think is a very pragmatic approach. It's a good budget.

The CHAIRMAN. Well, thank you. If there are no further comments, Mr. Burton.

Mr. BURTON. I will just take a moment, Mr. Chairman. It appears as though, as I was listening to Mr. Brown's testimony, that in some areas, OMB may be penny-wise and pound-foolish.

You were recommending, I think, 150 additional employees for loan servicing and from what I've been able to gather, that will save money instead of costing money.

Mr. BROWN. It will save about a billion dollars over a 5-year period, simply by adding about 150 new FTEEs.

Mr. BURTON. So, it would save about $200 million a year over the 5 years?

Mr. BROWN. Yes.

Mr. BURTON. Just by adding these people to perform this service?

Mr. BROWN. Yes, and that's based upon a study that was performed by the VA out in Houston which actually set up a special loan service unit, much like the private sector is doing it to prevent these foreclosures.

Mr. BURTON. I would just submit to our chairman and our ranking member that we ought to make that pitch to OMB because if hiring these people will save a billion dollars over 5 years, it seems to me that that would be the proper thing to do.

The other thing that I would like to just ask anyone of you is: Is there any wasteful spending that you've seen in the proposed budget that has not been illuminated by your budget where we might be able to transfer funds to perform the kind of vital functions you think are necessary? I mean, your budget is pretty specific, but are there any glaring examples of wasteful proposals in the Government budget where we could transfer funds to do a better job of taking care of the veterans?

Mr. RIVERS. Mr. Burton, I'm not sure that we would point out any particular area. We agree there are certain area——

Mr. BURTON. You don't have to be a politician; you can just tell us.

Mr. RIVERS. I can't honestly say that, off the top of my head, I can point to one area and say, this is foolish. As Jesse pointed out, though, we think it makes no sense to add FTEE in order to carry out deficit reduction when you could very easily add FTEE, as Jesse points out—and we point out in our budget, that will affect cost savings far beyond and also be of benefit to veterans.

We think that the way we ought to approach this thing, in essence, is that as we cut costs, let's make sure that it also provides a service to veterans. Instead of hiring an FTEE to be tracking down social security numbers to see if somebody's getting more in pension payments—a few dollars more than they should, let's figure out the ways that we can benefit the veterans by offering better counseling or better service or more employees to process these claims.

What we see happening is new FTEEs being added to the detriment of veterans to make sure we reduce the budget, rather than trying to do anything at all to make sure we deliver a better quality product in a lot of these areas. We could probably go down, given time, to each one and say we can do it a better way, and we think perhaps that's what we've done in this budget.

Mr. Brown. I'd just like to follow up on that. I think it also may boil down to a matter of priority. You mentioned wasteful spending. We think that last year's legislation contains some wasteful spending. For example, a significant amount of money was allocated to build a museum for Lawrence Welk.

Also, about $19 million was allocated to study the passing of gas of cows. We don't clearly understand what real benefit society is going to be able to get from that because we all know that gas from cows doesn't smell too good.

We think that we should be able to look at pork barrel projects and just kind of eliminate some.

Mr. Burton. Thank you very much. Thank you, Mr. Chairman.

The Chairman. I might say that looking into what Mr. Brown said about saving the money, we have a problem. We have to get the Congressional Budget Office to come up and say they can save that amount of money and then sometimes, it could be implemented by the Department of Veterans Affairs, but we will point it out, as you mention, Dan. It makes sense to me.

On these benefit claims, let's hope we don't go into major combat on the ground over there, but even if we don't, we will have a number of claims from the service personnel in the Persian Gulf for hurting their backs, hurting their knees, breaking their legs and so, you know, the Veterans Department has got its head in the sand if they think they don't need to be able to increase the benefits offices and the different regional offices around the country.

As it was pointed out, they're already 6 months or 9 months late in servicing these accounts, but they're going to really get some claims when these young men and women get back from the Persian Gulf because that's tough, tough terrain and some of them, whether we have combat or not, are going to have some claims.

If there are no further expressions of comments——

Mr. Burton. Mr. Chairman, one more thing: I'd like to submit a statement for the record.

The Chairman. Without objection, so ordered.

[The statement of Hon. Dan Burton appears on p. 219.]

The Chairman. I want to thank our witnesses, and, again, thank you for this Independent Budget.

Mr. Rivers. Thank you.

Mr. Brown. Thank you, Mr. Chairman.

Mr. Robert L. Jones. Thank you, Mr. Chairman.

The Chairman. I might say, as our panel is coming forward here, Dr. Kenneth Shine, Dean of the UCLA School of Medicine, a very distinguished professor, has been before our committee before, and we want to thank him again for the great job and the time he has taken to improve the medical care in our veterans hospitals, and Dr. Daniel Winship is the Dean of the School of Medicine at Loyola University of Chicago, also very distinguished, and Wendell Musser, who is Chief of Staff at the VA Medical Center in Atlanta, GA.

All our panels are distinguished, but the panel here, the panel that we are talking to this morning, has taken the time to be here, and we appreciate it, and I believe, Ben Jones, you wanted to say a special word about Dr. Musser, who is in your area.

Mr. **Ben Jones**. I do, Mr. Chairman. I thank you for the opportunity to introduce a constituent, and I am pleased to do that.

Dr. Musser is the Chief of Staff at the Decatur VAMC. He lives and works and resides in the 4th District, which I represent, and he has been the Chief of Staff there for over 10 years, and that hospital serves 430,000, almost half a million veterans, and he has brought great experience, because he was formerly Chief of Staff at the Lexington VA Hospital, was Chief of Laboratory Services at Durham, NC, great experience and a real understanding of the problems in the system and has continued his efforts to improve medical care for veterans.

He is past president of the National Association of VA Chiefs of Staff and a member of the Resource Allocation Methodology Task Force. He is also a professor at Emory University in the Department of Pathology, and he is an associate dean of professional services, and I know from a personal standpoint, for he and I have walked the halls of the VAMC in Decatur many times, and I know about his caring and compassion for our Nation's veterans, and I appreciate the opportunity to welcome you here, Doctor.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Ben.

I would like, at this time—Dr. Shine, your name is at the top of the list. We will let you be the first one to testify, and your full statements will be put in the record without objection.

STATEMENTS OF DR. KENNETH I. SHINE, DEAN, UCLA SCHOOL OF MEDICINE; DR. DANIEL WINSHIP, DEAN, STRITCH SCHOOL OF MEDICINE, LOYOLA UNIVERSITY OF CHICAGO; WENDELL MUSSER, CHIEF OF STAFF, VA MEDICAL CENTER, ATLANTA, GA

STATEMENT OF DR. KENNETH I. SHINE

Dr. **Shine**. Thank you, Mr. Chairman.

It is a privilege to be with you and with this committee again. This committee has taken important leadership not only in the areas of the physician pay bill, but in efforts to lift the honoraria ban on VA physicians, as well as its efforts to improve funding for VA health.

I am Kenneth Shine. I am the Dean of the UCLA School of Medicine.

We are fortunate in that we are closely affiliated with three major VA hospitals.

At the Wadsworth VA Medical Center, for example, we have pioneered in a number of approaches through the treatment of AIDS in veterans. We have programs for the homeless. We have proposed a new research facility as a joint venture between the University and the VA, and we have innovated in a variety of other kinds of health-care programs.

At the Brentwood VA Hospital, we have participated in important new programs in detoxification of veterans and have received some recent large Federal grants in the area of helping veterans with substance abuse.

The Sepulveda VA Hospital was the first hospital in the United States to demonstrate that a geriatric assessment for veterans, or for anyone, actually saved money, and it has become a model for other programs around the country.

At Sepulveda, we also have a joint venture with the VA in the only pilot program in the United States for developing ambulatory care and education. We sponsored a conference in the west coast for VA facilities on ambulatory education, and that has resulted in the western region, with the help of the regional office, becoming a major leader in this area.

I am also representing the Friends of VA Medical Care, and we have submitted a report of those recommendations. There are some 34 groups which have participated in that proposal, and I will comment briefly on the recommendations.

I think the previous speakers have very eloquently stated the state of the turmoil, crisis, and unhappiness in VA health care.

It is clear that during the late 1980s the operating budgets of VA hospitals were literally maintained by the cannibalization of monies for equipment and infrastructure and that we are now paying the price for that.

At Wadsworth VA Hospital, Building 114 has had leaking pipes for years. Nothing was done. This last fall, there was a flood. That building is inoperative and will be for at least a year, so that the offices of physicians and laboratories are not available.

Two pieces of critical x-ray equipment blew in the last 2 weeks because they were aged and inadequate.

We still do not have a fluoroscopy unit for electrophysiologic studies.

Our Chief of Surgery, who did his research at the VA hospital, after coming from Johns Hopkins 3 years ago, will no longer do that. He now insists that all of his research be done at Westwood, because the infrastructure support is inadequate.

This sends a terrible message to young surgeons, and he has recruited four young general surgeons to help at Wadsworth, but the fact that he cannot work there satisfactorily means that he is telling his younger people to come and work there, but that he has got to withdraw, and that is a very unfortunate message.

One of the most important scientists in the area of retroviruses, AIDS is a retrovirus, has been recruited to Parkland Hospital at Southwestern. It is a promotion for this man, but I have every reason to believe he would not have left if the infrastructure at Wadsworth had been capable of supporting him.

These are local examples, not necessarily designed to plead the case for that institution, but rather to make it palpable to you as to how the system is hurting. It is clear that, through your efforts and through the Secretary's efforts there has been some significant increase in funding of VA health; but as I think you are also aware, of the $976 million proposed additionally this year with mandated programs, one is actually going to end up taking $200 million out of operating activities.

We are playing a shell game, which is not going to be successful so far as health care is concerned. For that reason, we strongly support the recommendation of the Friends for a $14.9 billion budget for health care.

A comment about the Physician Pay Bill. I know that this committee and the Chair have been very active in supporting the efforts to get that bill through and we commend you for that. We urge you to continue your efforts. We are prepared to help in any way we can.

Unless we can provide ways to reimburse for certain kinds of scarce skills among the physicians in the VA, we are going to have great difficulty providing the kinds of services that we need to provide. We not only need to get the bill, but we need to get an allocation which, in fact, will pay for it. The discussions about $43 billion for a $63 billion ticket will not wash.

I would like to spend a moment on the VA research budget because this is an area that is of considerable concern and importance to all of us. Our ability to recruit the best and the brightest to the staffs of these hospitals is based not only on their sense of dedication and responsibility to give care, but also because they have an opportunity to have access to the VA research activity.

I cannot emphasize enough, in the current climate where NIH funding and other funding sources are limited, just how much leverage a relatively small amount of money in the VA research budget has. Because the money in the research budget does not pay indirect costs, and does not pay physician salaries, it goes for research.

I will point out to you that just in the last 2 years, VA scientists have made important contributions to the way in which high blood pressure is treated, using lower amounts of medication; and new medications to treat enlarged prostate glands, a subject that I get more and more interested in with every year; and the use of diabetic insulin pumps. VA scientists contribute to a whole variety of other things that help the health of veterans and also contribute to society.

The $217 million recommended by the Administration is not only no increase, it actually significantly decreases the amount of grants that are available in areas where we have substantial need.

Finally, we are all very much aware of the situation in the Persian Gulf. I am pleased to report to you that our faculties have indicated to our colleagues in the VA that our medical staff, surgeons and other specialists, stand ready to help them in any way that is required, in terms of meeting any emergency. We pray that that will not become a major factor. But we are prepared to help. We are also prepared to provide health care in our university hospital at that institution's cost.

In conclusion, Mr. Chairman, we laud the efforts of this committee in a variety of areas; but we believe that it is essential that we obtain a lifting of the honoraria ban, a proper institution of the pay raise bill, some restoration of meaningful funds for equipment, restoration of a reasonable overall budget and particularly we urge attention to the VA research budget, which at $281 million will fund a tremendous amount of good research and good people.

Thank you, sir.

[The prepared statement of Dr. Shine appears on p. 437.]

The CHAIRMAN. Thank you very much, Dr. Shine, that was excellent testimony.

I thought we would go through the other witnesses and then take questions.

Dr. Winship.

STATEMENT OF DR. DANIEL WINSHIP

Dr. WINSHIP. Mr. Chairman and members of the committee, I appreciate the opportunity to appear here today to give testimony concerning the Department of Veterans Affairs, fiscal year 1992 medical programs budget.

The $976 million, almost one billion, is a sizable increase in the VA health care budget. If those funds were to provide for current services plus begin to repair the erosion of the last decade or more of the VA health care purchasing power, this would be a very positive step; but unfortunately, that is not the case.

Simple arithmetic shows that of the 976 million, fully 860 million will be initially committed to fund inflationary expenses of personnel and all other costs and the remaining 116 million will fall far short of the VA's needs for even holding its own in its health care activities. The budget, in fact, fails to deal with some exceptional but unavoidable increases, such as pharmacy costs, which will far exceed the estimated 6 percent inflationary factor that has been presented.

So, once again, the overall funding level will result in a further erosion of an already inadequate budget before any real attention can be paid to repair of a chronically decimated infrastructure or to deal with implementation of important initiatives of the Department. In fact, I suspect that many of the initiatives that have been identified will not be carried out with this budget in 1992 because the estimates are so far short of what will actually be required.

I have thoughts about a number of the topics, but I want to mention only a few items in the budget. First, the management initiative of the workload shift from hospital to outpatient care, with its attendant reduction in 1,178 FTEE and $70 million. I predict this will not occur in 1992. Operationally, the reduction in FTEE and funds will not simply shift workload from inpatient to outpatient delivery, but will, in fact, reduce many inpatient programs beyond their ability to survive and simply will not be accomplished for that reason. Little shift will therefore take place, especially without increased resources provided to the already over-stressed outpatient services. Here lies a good opportunity to help the future of VA health care by adding resources to the outpatient services to allow the inpatient services to use their current resources to better advantage.

Nursing home bed conversions is an admirable goal, but the flaw in the rationale as presented in the budget, is that these are in the main, idle, unstaffed beds which will be converted. Therefore, shifting resources to staff the unstaffed beds and not adding new resources will again result in a decreased inpatient capability with the same result I just mentioned. I would predict that this initiative also will not be implemented with this budget. Once again, we will wonder why we cannot get this accomplished in the VA.

The increased funding for replacement equipment by $52 million is a positive step. The problem, of course, is that even this sum is far less than that which is needed. I doubt seriously that this level of funding will even keep up with the growth of the replacement equipment backlog. Last year the backlog was some $650 million. I understand it has currently grown to some $750 million this year, in spite of last year's budget. I will predict it will continue to outstrip the budget.

Specific attention should be paid to this item because it is one of several, but one of the most important budget issues in the entire health care program which deals directly with the ability of the VA to maintain quality care and where erosion in this area translates directly into eroding quality of care.

There probably is no more important piece of the budget for the welfare of VHS&RA than the $200 million plus which goes to research.

The fact that this budget has been straight-lined or worse for several years has resulted in a reduction in the number of investigations, in good grants not being funded, in good people leaving, and the research service trying to survive with obsolete equipment and inability to compete, etcetera.

I trust that Secretary Derwinski meant what he said, as he established the Blue Ribbon Panel on VA Research, when he indicated that he would follow their recommendations.

It is my understanding that they strongly recommended that sufficient funds to repair the research service be added to the budget before it is too late.

I also understand that the Department of Veterans Affairs actually did make that request, but the OMB did not heed it. I urge you to pay particular attention to restoration of this account to a status of fiscal health over the next 1 to 3 years, starting this year.

Continued reduction of the MAMOE account is totally incomprehensible to me. Staffing of VHS&RA Central Office activities has been reduced by one half over the last 5 or 6 years, while the complexity, the number of programs, the amount of Congressional and other requirements have grown enormously, seems completely unrealistic and totally dysfunctional.

If the budget must be reduced—and it is such a small portion of the overall budget that I cannot imagine that it must be—then specific statutory relief to permit the required work of the Central Office to be done elsewhere in VHS&RA, specifically in various field offices must be pursued. To do less will result in further crippling of the ability of VHS&RA to even begin to approach reasonable management of its administrative workload.

Thank you once more for the opportunity to comment on this proposed budget. I would be happy to answer any questions that you have.

[The prepared statement of Dr. Winship appears on p. 485.]

The CHAIRMAN. Thank you very much, Dr. Winship. Dr. Musser.

STATEMENT OF DR. WENDELL MUSSER

Dr. MUSSER. Thank you very much, Mr. Chairman. Mr. Jones, members of the committee.

It seems like I have a well worn spot before this committee. I would recommend you go back and read my 1979 testimony which I testified against the Carter budget.

Mr. Kennedy, it is really good to see you. I am glad you made it for my comment.

Let me hasten to add something. I am going to make some critical remarks about the budget. They are not critical remarks about people.

I think that the Secretary and the Chief Medical Director have done an admirable job in the crisis times of protecting the budget. But it is interesting that, in the increasing deficit that has occurred since 1977 is still there and is even greater.

I really bring you greetings from the battlefield. The battlefield of the war against disease. As one of those commanders in that battlefield I could tell you an awful lot of war stories. I will restrict my comments, unless questioned accordingly, to the fiscal year 1992 budget.

By the way, if there are operations people in the audience, I wish you would take note of where I am from.

The 1988 budget was a disaster. The 1989 budget was worse. I served on a blue ribbon panel to look at that 1989 budget, to determine the deficit in operating costs for current services which we determined to be $1.5 billion.

The 1990 budget was worse. The 1991 budget is even worse. It appears that my own institution will be $1.5 million short just in all other operating funds.

Now, it is perfectly obvious to the casual observer that this $1 billion is not real.

I will not repeat what we have already said. By the way, I am not reading from a formal statement. I am reading from my notes and my analytical analysis of the budget.

It would appear then that that deficit is even greater and that we are far behind the curve on addressing current services. It is interesting to note, for instance, the comments on the research budget.

You know, I really wish someone would understand what the research budget truly is. It is blood. It is penicillin. It is the necessary items to bring together that care package.

Because, without that research budget, as these two deans know, you are not going to bring together the necessary people to develop that care package. They are not going to come.

So, although by law it is a separate item, and all through the budgetary process, the appropriation process, it is a separate item, to me it is an integral part of the medical care appropriation.

Now, for several years we have recognized the deficit in equipment. It is interesting to note that we have never truly addressed it.

Dr. Shine, I think the deficit is closer to $1.3 billion when I call around to the various hospitals and ask about their out-moded equipment. When you get a hospital as old as mine, 25, 26 years old, things are going to be breaking down all the time. I know your situation at Wadsworth very well.

Another thing close to my heart is the construction budget. If you really want to close us down, if you really want to cripple us, there are two areas where you can zing us. Everybody sees the doctor. Everybody sees the nurse. That is the thing that is out front.

But the space, the structures, the maintenance of the structures are very important. If you look at this budget, there are only three major projects. The major projects account is $100 million in this budget less than it was last year.

If you look at what we ought to be doing, we ought to be having somewhere around $800 million in major alone, about $350 million in NRM, and another $200 million in minor projects.

Listed in the budget document itself is a deficit backlog of $839 million in NRM alone. I just wonder whether someone forgot to edit that out.

Let me emphasize in these last few moments that we are concerned about the care package for veterans, old and new, and the veterans to come to us in the future.

We would expect that the full spectrum of care is what you want. We realize the economic crisis and the world crisis in which we are living. We understand the competitive nature. We wish to address it. But we are going to have to face some very crucial prioritization problems. I do not have the answers. I have listened to this very erudite discussion of the Budget Office and the Appropriations Committee, et cetera. But it still does not change the fact that it is our fond hope that the ever-increasing needs that will result from casualties of Desert Storm will be covered by appropriate dollars.

Thank you.

The **Chairman**. I want to thank all three of our witnesses for that very fine testimony. And we hope, in talking to Mr. Stump, that we could ask you to come back sometime if we go before the Budget Committee or the Appropriations Committee, coming from individuals who are on the job every day.

I am not trying to embarrass anybody here, but we know we do have some people from the Veterans Department. For the record, will you stand up and identify yourselves, so we can know who all is here from the Department of Veterans Affairs.

Mr. **Buffington**. Bill Buffington, Office of Congressional Affairs.

The **Chairman**. Glad to see you.

Ms. **Mouvery**. Lynn Mouvery, Office of Congressional Affairs.

Ms. **Howell**. Sharon Howell, Budget and Finance staff.

Mr. **Deal**. Larry Deal from VHS&RA.

Mr. **Ramsey**. William Ramsey from VHS&RA.

The **Chairman**. That is DM&S, I believe.

Mr. **Ramsey**. No, sir; VHS&RA.

The **Chairman**. All right. The Chair has no questions.

Mr. Stump, do you have any?

Mr. **Stump**. Well, Mr. Chairman, I just want to thank them for their excellent testimony. It is too bad we cannot get them before the Budget Committee. I think it would have a great impact.

Dr. Shine, you mentioned about the research funds. Are we in fact getting close to maybe some of these medical schools wanting to disassociate themselves from the veterans hospitals?

Dr. **Shine**. I do not think there are any medical schools—I should not say that, because I have not done a poll—I doubt that medical schools want to disaffiliate. There is, as you know, a longstanding symbiotic relationship between medical schools and the VA facilities. I think all of them recognize the mutual benefit of that.

At the same time, you ought to understand the kinds of tensions and stresses that the medical schools are under. At the present time, their sources of income from the National Institutes of

Health are in jeopardy, their sources of income from practice activities because of managed care have been diminishing. So their capacity to, for example, supplement salaries for physicians in the VA are increasingly limited. And the difficulty that you get into is that, if you do not have an adequate package on the VA side, and if you cannot make it up because you do not have the discretionary funds on the school side, then you have to decide, are you going to settle for something of lesser quality or not.

Under those circumstances, there have been examples of schools which have disengaged from particular programs. That happened in New Haven, for example, 2 years ago, in which in particular departments it was clear they could not proceed. And I think that is the principal concern that I have, that the stresses and strains will result in a situation in which, because of the inability to maintain quality, schools will have to pull back. I do not think anybody wants to do that.

I am also fond, Mr. Stump, of pointing out that I had the good privilege years ago of being cardiologist to Omar Bradley. General Bradley told me that the most important thing he did as Administrator of the VA after the war was in fact to implement the affiliation of VAs with medical schools. It was ironic that years later he received his care in my coronary care unit, so we had a way of paying him back, if you will, for that very astute kind of judgment.

Mr. STUMP. Thank you, Doctor. And thank you once again for your testimony. I will say that this is probably the best panel that we have had before us all year long. Thank you.

The CHAIRMAN. Thank you. Just one question from me. How much money do you think we need in fiscal year 1992 to run our VA health care system, how much additional funding? That is a rather tough question, but does anyone care to tackle that? Dr. Musser, you have gone all out, might as well go all the way.

Dr. MUSSER. Well, sure, why not, Mr. Chairman?

We have thought about that on a national basis in various committees I serve on, and think-tank opportunities. It would appear that, just in equipment alone, we are $1.3 billion short, in operating budget probably another billion and a half, and then one has to figure out how they are going to play the construction crap game, which is a very difficult one; but if you look at it from that standpoint, we are at least $3-5 billion short of the mark. That might be in keeping with the Independent Budget, I do not know; I have not looked at the Independent Budget yet that closely.

Dr. WINSHIP. I would like to make a comment about that, Mr. Chairman.

I think that there are two ways that you might want to think about approaching that. One way is to ask what would it take to stop the downward spiral and stop the erosion to bottom out, and then begin to add some funds so that current services could be managed, important initiatives could be begun, and perhaps total repair be done not in 1 year, but at least initiated and then, say, amortize that over the next 3 or 4 years.

I believe that would be a figure that would be somewhere very similar to the budget numbers that the Independent Budget group has come up with, another billion, or $1.5 billion, I think, somewhere totalling $14 billion and $15 billion, for the budget of VHS&RA.

To accomplish the total repair is going to be much nearer the kind of figures that Dr. Musser has talked about, because we are talking about such things as the replacement equipment backlog, the NRM backlog, the hospital backlog. We are talking several billion dollars to actually accomplish that.

I believe the Independent Budget would be enough to turn the course around to begin to improve the situation.

Dr. **Musser**. I would agree with that. My comments were a total package; and one has to be reasonable. There is no way that we can address the total deficit. I firmly believe in my heart that the likelihood of us getting significant increased dollars in the upcoming budget are very close to zero, because of the realities of the economics of the country and other pressures placed against us.

The only thing that I would urge and would hope that some of my friends in the audience might take back is that are we sure that the distribution of the present dollars is adequate and equitable? And I will spell that latter word if anyone has any problem with it.

Dr. **Shine**. If I could just comment, just very briefly, that I believe that the recommendations of the friends are thoughtful, meaningful, and that those are appropriate numbers. I think all of us recognize the budget crunch, but I honestly believe that we have to be advocates for the people who are being cared for here and for the people who are giving the care. If we do not work as hard as we can to come as close to that number—and I think that is a number close to $15 billion, which is a heck of a lot of money—if we do not work very hard at that, we are not living up to our obligation, either to veterans or to the people who are trying to take care of them. I believe that we have to agitate for these funds. Mr. Stump, I would be happy to go to the Appropriations Committee or anyone anywhere else on behalf of them, because I see these folks every day in terms of trying to provide care, and we have to accomplish this goal, I believe.

Ms. **Waters** [presiding]. Thank you very much. Mr. Stump, did you have any further questions?

Thank you for your very, very informative testimony here today.

Mr. **Ben Jones**. Madam Chair.

Ms. **Waters**. Yes.

Mr. **Ben Jones**. I had a question.

Mr. **Waters**. Before you, Mr. Kennedy, I believe, and then Mr. Jones, you will be next.

Mr. **Kennedy**. Thanks. If you do not mind, I am in a jam this morning, which you have already pointed out, Dr. Musser. I do want to, first of all, apologize for not being able to hear all three of your complete testimony and some of the earlier testimony. Sometimes it just gets into a jam around here; but to be honest with you, I think I looked forward to the three of your testimony not only this year, but in times past, because of the honesty and straightforwardness with which you address the committee on the deficits that have been occurring with the medical budgets over the course of the last several years.

Particularly, I wanted to pay attention to some of the issues that all three of you have identified, which is the growing lack of attention that is being paid to a lot of the accounts that deal with not only the patient care, but deal with the overall sustaining of the hospitals themselves.

Since I have been here now, each and every year we hear numbers that are at least $1 billion that are dropping. Now, the fact is that, as Members of Congress, you also hear testimony from all the hospitals in the country that scream that they are not getting enough money. And yet I notice that most of the hospitals in my district somehow or another keep the doors open and keep the payments moving.

What I wonder is whether or not you can tell us, in the most straightforward way, the kinds of realities that the patient care within the hospitals are going to anticipate suffering as a result of the decline that is taking place with our funding levels for the basic hospital structures and whether or not the two lines cross at a certain stage.

We have heard, Dr. Musser, you remember, last year, about the postponement. We heard the VA come in and tell us that all patients were being taken care of. There was not a single delay that had taken place in patient care. Then all of you came forward and said now wait a minute, wait a minute, that is not a completely accurate case. What we are doing is we are postponing a lot of the chemotherapies; if a Category A veteran comes in, what we do is we tell him that he has to come back 3 or 4 months later for scheduled surgeries, that patient care is in fact suffering. I wonder whether or not you are actually going to be able to tell us, given the fact that you have been working on these budget issues for some years now, whether you can address to us specifically the kinds of patient care that will deteriorate as a result of the lack of funding that is taking place.

That is for all three of you.

Dr. Musser, why don't you start, please?

Dr. **Musser**. Thank you very much.

Let me tell you what I signed in as an order at 3 p.m. yesterday afternoon.

The budget officer came to me with the associate director and said we are $555,000 in the red, with a projected million and a half, and the operations people, who are our friends, say we have no money; you are going to have to do something.

So, what I do is that you cannot do anything in those categories without the approval of the Chief of Staff, all the way to the top, case-by-case review, hassle, delays, case by case.

I put myself in jeopardy, because I am a mere mortal. I do not have a crystal ball. If I guess wrong, I could hurt somebody. If I guess right, all we have got is a delay, which I hate, but a necessary delay for survival purposes.

So, I introduced that order, and now all of my service chiefs and my medical specialists—and it will ricochet back to my dean, who happens to be a good friend of mine, thank God, and of course, you know, Jeff will understand, but that is what you do.

You extend things out. You make choices. You, in essence—and I am glad the chairman has gone. He and I are dear friends, have known each other for 25 years, but he gets upset when I say we ration care, Mr. Chairman.

Mr. Congressman, we ration care. We create queues. We try to play a crap game and try the best to not erode quality and not hurt anyone. That is what we do.

Mr. **Kennedy**. Thank you very much.

Dr. Winship.

Dr. **Winship**. Earlier this week, I asked Dr. William Best, who is the Chief of Staff at the Hines VA Medical Center, with which we are closely affiliated, to provide for me his thoughts about what is really happening in that hospital, and he gave me a whole sheaf of things here. Let me mention a few of these.

Hines is a very large and very complex hospital, one of the most complex and one of the largest in the entire system, has a lot of different programs. Let me give you an example of some of the things that we do and do not do, however.

Hines has a very large open heart surgery program, fairly large, I would say, for the VA, not nearly as large as the University has, but it is a combined program. Hines is doing heart transplants. There is a drug requirement for transplant surgery, cyclosporin primarily, that the patient simply must stay on from then on.

Hines has to limit the number of transplants it does because of its inability to commit to long-term expensive cyclosporin in a large number of patients.

Furthermore, it is absolutely unable to take on any patients from any other VA hospital who may have had a transplant elsewhere but is now in the upper Illinois/upper Indiana area and who would naturally come to Hines for that care.

If Hines has not performed the transplant in that patient, they cannot treat the patient. That patient cannot be cared for at Hines for that purpose.

That is not state-of-the-art medicine, to not be able to do that when you have a program.

The program is excellent in terms of the success rate. It is superb.

Hines has a very sizeable list of veterans who need artificial joints; this is a litany that you can hear in VAs around the country.

There is a waiting list for artificial joints, hip replacement and people who really need that, that may be as long as a year at times.

Now, that is not good health care. That is erosion of quality of health care.

I am not talking about the quality of the individual care of the individual patient at the bedside and the professional-patient interaction. That is good, and I do not think we have to be too concerned about that, but for the overall population that we have, those are examples of the kinds of things that we cannot do.

A marvelous new drug that is recently on the market, called erythropoietin, is valuable in several ways, but one of its value, is for people who are on venal dialysis. They take erythropoietin and then they do not have to have transfusions anymore in the main.

We have erythropoietin but we cannot give that to all the patients we have on dialysis, and in fact, we limit chronic dialysis now, ration it because of our inability to fund erythropoietin in the amounts that we need.

Those are some of the things that do not appear in this budget, those kinds of requirements that are more than just the 6-percent inflationary cost increase that is recognized in the budget. Those are some examples.

Dr. SHINE. Could I just make a couple of quick comments?

Ms. WATERS. Yes.

Dr. SHINE. (A) The Secretary should be commended for doing quality of care and quality assurance research, but it will not show you any of this.

It does not show you the people who die because they never get in to have a transplant. It does not show you the people who drop dead because they cannot get into the outpatient department.

Secondly, you mentioned the private sector. The private sector has learned how to shift to the ambulatory arena. We are doing, in our University Hospital, 30 percent of our surgery on an outpatient basis. It is very difficult to do that in the VA system, for two reasons.

One, the reimbursement system is wrong. You get more credit for a procedure done as an inpatient than an outpatient. That ought to get changed.

Secondly, we are working with a certain number of beds, and we are protecting beds for reasons that are of historical value, when we should be, in fact, protecting programs.

Third, if you are going to move to the ambulatory arena, if you are going to provide the care, it has got to be timely. If it is not timely, then the only option is to hospitalize the patient.

So, you have got to decide. Do you want a first-class ambulatory opportunity program, where people can get in quickly, get diagnosed, a decision made about what to do, and get proper treatment?

That is why these waits in the ambulatory area are so critical, because you are obliged to move from an inpatient to an outpatient mode. That has happened in the private sector, but in the private sector, you can get to see the doctor tomorrow. In fact, if you have got chest pain, you will see him tonight. In this system, you may or may not, and under those circumstances, that is where the real threat is.

So, I think it should be clear that the private sector has been able to adapt to a situation, and again, I want to make very clear—in our region, for example, we have gotten terrific support from the regional office to try to help us to innovate, to develop systems.

I think it is very clear that the Secretary, and Mr. Principi, are aware of the importance of moving in the ambulatory direction, but I think you ought to understand that that is not a panacea and that, unless it works well, people may die who never get into a quality of care assessment.

Mr. KENNEDY. Just as a follow-up comment, I just want to say again how refreshing it is to hear from you. I would like to work with you, particularly on the points that you have raised, Dr. Shine, with regard to some of the reimbursement program rates and the like and try to—if there needs to be legislative action to address those problems, I would like to work with you on it.

I think, Dr. Winship, it would be important, if you have not already submitted it for the record, the specific cases that you had outlined or the memo that you had received. I did not quite follow who it was from.

Dr. **Winship**. It was from Dr. Best, the Chief of Staff at Hines. I would be glad to do that. I will not submit that memo, because it would not be appropriate, but I will extract it with the information you requested.

(See p. 489)

Mr. **Kennedy**. I think it would be enormously helpful, and I guess, to the committee, it just seems to me that, at some point, we are going to get to a stage where people—Dr. Shine is the first person I have ever heard say that people are actually suffering and perhaps even dying as a result of the fact that they were not able to get the care, and I think that that opens up a whole new element for the committee to be able to acknowledge that people are not getting the proper medical care that they deserve and that was promised by their Government when they served their country. In fact, this gives us some extra leverage in going back to the Appropriations Committees and the like to be able to receive the funds that are necessary to meet the veterans needs, not that meet OMB's needs.

Dr. **Shine**. Madam Chairman, I want to make it clear, I have not said specifically that I can identify a specific death. What I am saying is that the quality-assurance program, which looks at how the care is given once you are in the hospital or even in the outpatient, does not tell you about those other risks.

Mr. **Kennedy**. No.

Ms. **Waters**. I think that we got the point. Whether, then, the direct documentation—you are alluding to the fact that there is some rationing based on an inability to follow up with certain kind of medications, in particular.

Mr. **Kennedy**. I want to thank the Chair for the extra time.

Ms. **Waters**. You are certainly welcome.

Mr. Jones.

Mr. **Ben Jones**. Thank you, Madam Chairwoman.

Mr. Kennedy's question sort of address mine, too. We talked about war stories, and you are sort of reporting from the front, and I think you have touched on a lot of the ways that this erosion that you allude to over the last decade or so——

Dr. **Musser**. Seventy-seven, really, Mr. Jones.

Mr. **Ben Jones**. Well, that is 14 years now.

Dr. **Musser**. Yes.

Mr. **Ben Jones**. It is 14 years of shortfalls that are now starting to have a very genuine effect.

Obviously, as our veterans population is aging and in need of more care, we reach a critical point, and I do not think we can emphasize too much how critical it is.

We hear it every day from the veterans, in our district offices, the calls from constituents about the problems that they are having at VA MCs, and as Mr. Kennedy pointed out, it is really refreshing to hear it from you, because we are sort of caught in the middle of a most difficult situation, but I do think that now it is very timely.

I think that—I cannot remember a time when the Nation was so focused on the needs of our troops in the Middle East and on their future needs as veterans and reassessing, too, I think, the Vietnam experience with the veterans there, and as—I think it was Congressman Applegate pointed out earlier, if we can marshal this as a political force, the 28 million or so veterans out there, I do not think there has ever been a better time to say enough is enough, we are at that critical point, and bring real attention to the shortfalls and try to correct the situation so that we can have top-of-the-line care and help you in getting the things that you need.

I don't want to go on with more war stories. I think it would be very valuable at some point in time to bring those in because that's very vivid evidence of the crisis.

I want to thank you for coming. My colleague from Texas did have a specific question, he had to leave, for Dr. Winship, and he wanted to know what you thought the impact on the timing and viability of the plan, the $315 million construction project in Dallas, what is going to be the impact of the budget's proposed staight-lining of the major construction appropriation of $450 million?

Dr. **Winship**. Well, obviously, the construction budget of $450 million, which I think is down some $150 million from last year, which wasn't enough, is only going to allow a very small number of major projects to be done. I do know that the Dallas project has been well planned for a long period of time. I think it has slipped already a few times. I doubt very seriously that the VA is going to see its way to use virtually all of its construction budget for one project in a given year, and I would agree with that. If I were still there trying to help manage that operation, that wouldn't make much sense when the needs are so great and when the VA has been in effect living off its facilities for long. So many of those VA's have major needs and are all of very high priority.

I haven't thought about that in several months, so I am not able here to really say where Dallas should fit in the priority but it's very clear that it's going to have to be rethought in view of a $450 million budget. As much money as that sounds, it is a drop in the bucket for the kind of facility needs that this system has.

Mr. **Ben Jones**. Thank you.

Dr. **Musser**. Mr. Jones, for the record, let us point out, I'm sure all of you have looked at this carefully, that there are only three major projects.

One of them is a clinical improvement at North Chicago. Actually it's environmental improvement. It's Phase 2 of that project.

The second project, seismic changes in Palo Alto.

The third project is a clinical addition at Tampa.

Now, true, there are some clinical improvements at Dallas, Salem, and St. Louis, but that's not what the Congressman is really talking about. He is talking about the major project.

Let me state one other thing for the record, since many years ago when hospital construction service was in Department of Medicine and Surgery and I was an ACMD, I had a good deal of input into it. There is staff in the construction service in Central Office to put $800 million of major projects out in addition to the $350 million in NRM and other projects.

I think the committee also ought to know, I found out a little interesting thing, that OMB attempted to put $100 million cap on major projects. Well, now, you think of what any major project really runs in today's costs. You are going to build a standard hospital anymore you're talking about at least $200 million. A $100 million cap on a major project would have destroyed the program and I submit to you that this is a very good way to, as we say, slip the Gurka knife into the soft underbelly of the organization. That we would like to avoid.

Thank you.

Ms. WATERS. Mr. Stump.

Mr. STUMP. Thank you. Doctor, let me ask you one question.

A while ago when you were talking about your shortfalls and having to ration your medical care in a sense, do you have or what mechanism do you have to report those shortfalls back to the Central Office in VA?

Dr. MUSSER. We have through the regional office the opportunity to present these deficits. In addition, these deficits in the accounts show up off the computer. We make them readily aware of it as we have the impact of, you know, Desert Storm and Desert Shield on us, which has had a monetary impact, and the agency is addressing the potential impact and going to collect data on that so there is a mechanism for if not almost daily at least weekly reporting these deficits.

Mr. STUMP. Well, I can assume you we're going to look into that, because I'm not too sure that we get that on this end from downtown.

Dr. MUSSER. Probably not.

Mr. STUMP. Thank you.

Dr. SHINE. Could I respond as well, sir, that these are hard data to get in many ways in terms of the actual outcome. My comments about the fact that a significant amount of the research budget is targeted toward health services research in no way demeans the importance of that research.

We have a variety of projects with the Rand Corporation in which we are trying to look at some of those issues and one of the important questions for health services research is how in fact do you quantitate that impact which is not what the survival is after cardiac surgery but what happens to a veteran who has a heart problem in terms of being able to get timely and effective care and what happens over time.

We are committed—that is a major research issue, both methodologically and otherwise, so a lot of this material appears in the minutes of Dean's committees. It does get back to Central Office in an anecdotal way. What we're interested to do is doing more research that allows us to quantitate it.

Madam Chairman, I do have to say, sitting here though, having watched you on a number of occasions in California, it's a thrill to see you in the Chair here.

Ms. WATERS. Thank you very much. With that I would like to thank you all for your wonderful and informative testimony here today.

We are very appreciative and this committee is very much in line with trying to do everything that it possibly can to right the wrongs of the past and to be supportive of funding in any ways that we can.

I have heard it from all the members here one way or the other. Thank you for being here with us today.

We're going to get our other panel up.

We have a third panel that we need to hear from: Mr. John Hanson, Director of the National Veteran Affairs and Rehabilitation Commission, the American Legion; Mr. Richard W. Johnson, Director of Legislative Affairs, Non Commissioned Officers Association; Mr. Thomas A. Sherwood, Executive Director, Vietnam Veterans of America.

Ms. **Waters**. Welcome. Please start right in with your testimony in any manner that you would like.

We have members who must get to other places but I assure you that even though they are not here that your testimony is being recorded and they will have access to it, so if you'd like to start, either one of you.

Mr. **Sherwood**. All right. I'll start.

Ms. **Waters**. Mr. Sherwood, please go right ahead.

STATEMENTS OF JOHN HANSON, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; RICHARD W. JOHNSON, DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION; AND THOMAS A. SHERWOOD, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

STATEMENT OF THOMAS A. SHERWOOD

Mr. **Sherwood**. Ms. Chairwoman and members of the committee, Vietnam Veterans of America appreciates the opportunity to present its views on the fiscal year 1992 veterans programs budget.

Given you have before you our complete statement, I will only make a few comments.

The savings the VA are to achieve over the next 4 years are a part of the veterans contribution to a failed deficit reduction program which has not met its 1991 targets for a balanced Federal budget. We note that in relative dollars the VA budget is getting smaller while the overall budget of the Nation is getting larger. This implies a shift in priorities away from veterans at an even greater rate than usually perceived.

Veterans are subject to what appears to be a quadruple whammy. As citizens they will have to pay for the S&L debacle. They will have to bear a share of the burden for the interest on the National debt and inflation. They will bear the burden of cuts the VA will have to sustain.

Finally, for many veterans, there will be no safety net. We are concerned that the brunt of the agony associated with sorting out which parts of the veteran's body is service-connected and which are not—will fall to the veteran, once he or she engages the system. We need to be aware that we are asking those who serve this country in total to be serviced in parts. That is, we are asking veterans who have served as complete human beings to now be serviced in parts. We would assert a principle of holistic medicine, which asks a person to be treated as a whole person with dignity.

We understand the principle of limiting treatment to service-disabled veterans as budget priorities may dictate. It is a principle we support. The VA will have to do a much better job of treating the veteran as a whole person, such that when a veteran who is service connected presents to a VA facility with a non-service connected disorder, he or she is not made to feel inadequate.

Surely, in the eyes of some, this system is going great guns—what with improved salaries, the increased attention and prestige brought on by cabinet-level status, the increased modernization and the increased largesse to providers and sentinels of veterans affairs. However, allow me to quote a veteran terminating a visit to a tertiary VA medical center; a veteran who really is not doing well.

"When I go to that place, with all its machines, all its white coats, all its people and all its money, I have a real feeling that place is not for me or my fellow brothers and sister veterans. It is a place for the people who run it, but not for me."

I spoke to a veteran as recent as last week and his comment was after adversely engaging a VA tertiary hospital was, "I know that place, but they do not know me."

Thank you very much.

[The prepared statement of Mr. Sherwood appears on p. 518.]

Ms. **Waters**. Thank you very much. Are there any questions, Mr. Stump, you have of Mr. Sherwood?

Mr. **Stump**. Why don't we go through all of them?

Ms. **Waters**. All right. We will go on to Mr. Johnson.

STATEMENT OF RICHARD W. JOHNSON

Mr. **Johnson**. Thank you, Madam Chairman. In deference to the lateness of the hour, I will attempt to limit my comments. But, before beginning my substantive remarks this morning, with the committee's indulgence, I would like to take a minute to introduce to the committee Dick Schneider.

Dick has recently joined the NCOA staff as our Deputy Director of Legislative Affairs, Retired Air Force Chief Master Sergeant, Vietnam veteran, whom I know will enjoy the same fine hospitality that we all have before this committee in the past.

Madam Chairman, NCOA has again this year endorsed the Independent Budget for Veterans Affairs, presented by our colleagues from AMVETS, Paralyzed Veterans Association, DAV and the VFW.

As so ably pointed out in that printed publication, the Department of Veterans Affairs has suffered from 10 years of erosion and degradation in funding. Furthermore, the 5-year budget agreement reached last year and ratified last year, almost assures continued degradation in the future. This is compounded by the fact that veterans benefits are, in fact, the only Federal entitlements which have been systematically cut by Congress and the Administration in recent years.

Obviously, this is the wrong signal to send to our Persian Gulf veterans and those who have served before them. We cannot judge the treatment our Government affords its veterans during these fiscally difficult times. History will do that for us; but won't it be a shame on this Nation as a whole, if after all it spends on prosecuting this war, that it does not spend a fraction more to provide for the veterans that serve it.

In one of the few areas of disagreement we have with the Independent Budget, NCOA believes that benefits traditionally associated with wartime service in the U.S. Armed Forces should be made available to Persian Gulf veterans. That includes free education benefits, without participation fees, for those who serve 180 days of active duty, 90 days during wartime, including those people now serving in the Persian Gulf who joined between 1977 and 1985, when there was no GI bill, and including our reservists who satisfy the active duty and wartime service requirements. That same wartime service requirement is the one that their predecessors had to serve to obtain these same benefits.

There should also be free home loans for Persian Gulf veterans, not loans requiring fees and downpayments. Veterans of the Persian Gulf should be able to expect vocational rehabilitation training, if needed, without having to meet some artificially and economically set level of disability.

In short, veterans of the War in the Persian Gulf should have the benefit of readjustment programs and benefits that helped George Bush become President today, and that helped many members of this panel rise to the level of leadership and success that they enjoy today. We owe this treatment to these veterans.

In one other area that I would like to discuss this morning, in the limited time available. The Non Commissioned Officers Association wishes to strongly endorse the Department of Veterans Affairs DIC Reform Proposal. Enactment of this proposal would fulfill a long-time goal of the Association and it would finally eliminate the last vestige of rank-based disparity in VA benefits.

Certainly the association would have been pleased if a higher minimum compensation level had been chosen by the Administration. While we realize these numbers are budget-driven and we are prepared to set aside our parochial interest in this issue to provide survivor equity. We urge our brother organizations and the members of this committee to do the same to gain early passage of this proposal. With that, I will conclude my remarks this morning.

I do thank the Chair for its indulgence.

[The prepared statement of Mr. Johnson appears on p. 524.]

Ms. WATERS. Thank you very much. Mr. Hanson.

STATEMENT OF JOHN HANSON

Mr. HANSON. Madam Chairman and members of the committee, thank you for the opportunity to present the American Legion's views of the Administration's proposals for veterans programs for fiscal year 1992.

A complete statement has been submitted for the record. I'll summarize here today. Our National Commander, Robert S. Turner, testified before a joint meeting of the House and Senate Veterans' Affairs Committees last September and itemized some of our concerns for the coming year.

Commander Turner's statement was an honest and realistic appraisal of where the Department of Veterans Affairs had to go to regain some of the ground that had been lost during the past decade. As each of you is aware, the American Legion supports full funding for veterans programs.

That commitment from this Nation is the very least we should do as a society. Keeping faith with the men and women who served for us and protect us is more than just one of the wages of war. It's what we must do if we expect future generations to follow in their and in our footsteps.

First, I'd like to address medical care programs. Despite this year's Administration request of a nearly $977 million increase for medical care, the current request is still short of the $143 billion Commander Turner asked for last September. We stand by that request as a minimum standard if VA is to be able to deliver medical care to its current caseload.

Since fiscal year 1980, health care has increased by $6.5 billion through the current fiscal year. In constant dollars, that increase is more on the order of $600 million. That's just more than 10 percent of an increase over 11 years. While medical inflation has increased annually in double-digits, VA health care got boosted in real terms by less than 1 percent per year.

A disturbing feature of this budget proposal is the reduction in the medical and prosthetic research program. As we indicated in our submitted testimony, the three elements of VA health care, clinical care, education of health manpower and research, are not independent components, but must be allowed to mesh together for the whole to be formed.

Similarly, VA research does not benefit veterans alone; society gains when VA-sponsored research succeeds. The proposed straight line funding request of $216.8 million is just not enough. Perhaps the message here is that the Administration is no longer interested in VA staying at the cutting edge of medical research. We hope that is not true.

In real dollars, funding for medical research has decreased by $35 million since 1985 and that is not a commitment to excellence. A blue ribbon research committee review of VA research programs submitted its report to VA last month and recommended a funding level of $280 million during fiscal year 1992. We urge funding at that level.

The budget for the Veterans Benefit Administration also worries us. Overall staffing support for the veterans services program will be reduced by another 31 FTEE below the 1991 level. We honestly believe that assumption of reduced caseloads are wrong for a number of reasons, including proposed personnel cuts for the military and the as yet unknown impact of Operation Desert Storm. Those reductions can be devastating to the delivery of earned benefits.

In the past 10 years, for example, regional office adjudication personnel have been reduced by 35 percent. Legislative changes which are aimed at improving VA due process and appellate procedures have added to the regional office workload. Decisions by the Court of Veterans Appeals are affecting the speed with which decisions are made.

It's clear to us that VBA needs more staff, not fewer. That staff must be well-trained as the medical issues they must deal with become more complex. There are legislative proposals we are concerned about as well, but we'll respond to two in particular.

One is the plan to index future cost of living adjustments for disability compensation to the Consumer Price Index. As you know, we oppose this effort. Obviously we want compensation benefits for service-connected disabled veterans and survivors to keep pace with increases in the cost of living, but it is important to note that each year in legislative hearings on the COLA, increase have provided an opportunity for the discussion of other compensation related issues and we would like that to continue.

We are opposed not only to the provision of the Budget Reconciliation Act of 1990 to limit certain incompetent veterans—to limit the estates of certain incompetent veterans, but also to the idea of making those limitations permanent. It's grossly unfair. It discriminates against veterans suffering from severe mental disorders.

Now, we recognize that this budget was put together before Desert Shield and Desert Storm and we appreciate the Secretary's attempts to try to find more money for certain veterans programs, but since January 17th, Congress has responded with dozens of proposals to help the veterans of Desert Storm.

Some of the most innovative approaches have come from members of this committee. The American Legion commends this committee for its leadership on this issue and we look forward to working with you to address the special needs of the men and women in the Middle East. We also know that whether we're looking at new proposals or improvements, Congress must find the money to pay for them.

In the coming months, we'll be looking at your proposals and we'll be developing our own initiatives. Those are just a few of our concerns. They're covered in much more detail in our presentation to the committee. Thank you for your time.

[The prepared statement of Mr. Hanson appears on p. 491.]

Ms. WATERS. Thank you very much, Mr. Stump.

Mr. STUMP. Thank you, Madam Chairman.

Let me first say what I asked the first panel today, whether you would be willing to carry your support to the level of the Budget and Appropriations Committees, because your problem is not here. We will undoubtedly increase this request that comes down from the President, but that probably your best effort could be made from your organizations and the respective states of those members sitting on those committees. I mean, that is where the pressure comes from. If your commanders back home can go to the members sitting on those committees and tell them how important this is, and work from that angle to contact the member, I think it would have a big impact.

I was a little surprised to hear you say, Mr. Hanson, that you oppose tying the COLA to the CPI, which would make it an automatic thing, and we would not have to go through what we did before. Would you other gentlemen comment on that, whether you would object or whether you think it would be better if we tied the cost-of-living increases to the CPI, and not have to fight this battle every year like we did this time?

Mr. JOHNSON. Mr. Stump, we have traditionally supported the American Legion's position on that issue. However, I expect that next week our National Commander, in presenting our 1991 legislative goals to the committee, will in fact announce that we do support indexing COLA increases for compensation and DIC programs, and will ask that that legislation be advanced this year.

Mr. STUMP. Thank you. Thank you, Madam Chairman.

Ms. WATERS. Thank you very much.

Let me just ask, it is my understanding that the Administration's proposed reform of the beneficiary travel program would deny veterans living within 50 miles of a VA facility payment for the cost of emergency ambulance travel, special mode transportation, as well as for the cost of travel for frequent treatment, such as dialysis care.

Is this a good or fair reform? Are you aware of this?

Mr. SHERWOOD. Yes. I think it is not a fair reform. As I had pointed out in the statement, there is a tendency to forget that travel within municipal areas is very expensive and although one may live in the city, getting from one side of the city to the other side of the city can be an extremely expensive experience, a very difficult experience.

So, whereas we certainly understand the issues, and we have spoken to that, relative to rural transportation, which is a major problem for veterans, we should also remember that even within cities it is very, very expensive for veterans to try to maneuver that.

Ms. WATERS. Thank you very much.

Let me just say, Mr. Johnson, I do believe that some of the items that you referred to in your testimony are being addressed in H.R. 908, the chairman's bill; and let me just say, without getting ahead of the chairman, relative to some of the concerns that have been mentioned here today, that I think a number of members here are concerned about the supplemental requests that will be coming from the Administration. We would like to see some of these items addressed in that supplemental request. Where it is at this point I do not know, but I have let it be made known to I think the chairman and everybody else, for those who have real concerns about additional expenditures, that there are some of us who would like to be real advocates for additional dollars in the supplemental request in order to address some of these issues, and have no problems with that.

So I am looking forward to what I can add in any way that I possibly can to support for those requests, and welcome your support; and I would urge you to follow the recommendations of Mr. Stump about what you do in the local areas. I think this is a prime opportunity to get these issues before the American public and get a lot of support.

Thank you for your testimony here today.

Mr. SHERWOOD. Thank you.

Mr. JOHNSON. Thank you.

Mr. HANSON. Thank you.

Ms. WATERS. I think there are no more questions, and our other members are probably on the floor at this time; and with that, this committee is adjourned. Thank you very much.

[Whereupon, at 11:50 am., the committee adjourned.]

APPENDIX

Opening Statement of Congressman Don Edwards
Veterans' Affairs Committee 2/20/91 hearing
on FY1992 Department of Veterans Affairs Budget

Mr. Chairman, I join with you in welcoming our good friend and former colleague, Secretary Derwinski, to our hearing this morning.

I know the DVA struggled long and hard to develop this budget proposal we have under consideration today, and I compliment them for their efforts.

I do want to note particularly that construction money has been allocated for the reconstruction of the Palo Alto VAMC, which you all will remember was so severely damaged from the earthquake in northern California. Palo Alto's restoration is desperately needed, so I applaud the budget allocation of $40 million to move us down the road on that.

I do have concerns about this proposed budget which I hope will be addressed this morning, and I'll mention just a few.

While the proposed budget for medical programs goes up $974 million, the vast majority of that increase is for inflation and salary increases. It concerns me that there is no money for necessary improvements, nor is Desert Storm factored into this budget in any way.

It also concerns me that the proposed budget places further restrictions on eligibility for vocational rehabilitation.

The reduction in eligibility for beneficiary travel is very disturbing. The adjudication system has long been a deep concern of mine. I'm perplexed that as processing time and error rate for claims are increasing, the budget does not support any improvement in this system. I believe it's obvious it cannot continue to function as it has been, with a turnover of staff at 50% or more in some urban areas.

And, I've been informed that the new VA cemetery in Northern California is ready to go, but it can't open because there is no staff for it. Yet, this budget calls for a reduction of 37 FTEE for the national cemetery system.

Well, I don't want to take up any more time. Suffice it to say that this proposal raises many serious concerns, and I look forward to the presentations that will be made here this morning.

REMARKS OF HONORABLE BOB STUMP

HEARING ON FISCAL YEAR 1992 BUDGET
OF DEPARTMENT OF VETERANS' AFFAIRS

COMMITTEE ON VETERANS AFFAIRS
FEBRUARY 20, 1991

THANK YOU, MR. CHAIRMAN.

I ALSO WANT TO WELCOME SECRETARY DERWINSKI, TONY PRINCIPI, DEPUTY SECRETARY AND THE OTHER VA OFFICIALS HERE TODAY. I ASK UNANIMOUS CONSENT THAT MY COMPLETE REMARKS BE INCLUDED IN THE RECORD OF THIS HEARING. I BELIEVE YOU HAVE CORRECTLY CHARACTERIZED THE FY 92 BUDGET AS BARELY A CURRENT SERVICES BUDGET WITH INCREASES IN SOME AREAS, AT THE EXPENSE OF OTHERS.

OUR BIPARTISAN RECOMMENDATIONS TO THE BUDGET COMMITTEE WILL LARGELY BE BASED UPON WHAT WE HEAR OVER THE NEXT TWO DAYS ABOUT TWO RATHER LARGE DOCUMENTS, THE ADMINISTRATION'S PROPOSED 1992 BUDGET FOR VA AND THE CORRESPONDING INDEPENDENT BUDGET PROPOSAL FROM MAJOR VETERANS' ORGANIZATIONS.

MR. CHAIRMAN, I WANT TO ASSOCIATE MYSELF WITH YOUR STRONG STATEMENT. SECRETARY DERWINSKI AND HIS TEAM SHOULD BE COMMENDED FOR THEIR EFFORTS TO OBTAIN THE RESOURCES NEEDED TO BEGIN REVITALIZING THE VA. UNFORTUNATELY, THE FINAL BUDGET NUMBERS ARE ALL TOO FAMILIAR FOR OUR NATIONS VETERANS.

WE MAY BE AT A WATERSHED WITH THE VA'S BUDGET. IT IS NOT NEWS TO ANY VETERAN THAT VA OPERATIONS IN ALMOST EVERY AREA HAVE BEEN STRUGGLING FOR A LONG TIME WITH UNDERFUNDING. BUT NOW PUBLIC SUPPORT FOR OUR MEN AND WOMEN IN THE PERSIAN GULF WAR IS OVERWHELMING, AND I BELIEVE THAT SUPPORT MAY WELL TRANSLATE INTO A NEW COMMITMENT TO VETERANS PROGRAMS FOR OUR MEN AND WOMEN AFTER THEY COME HOME. THE WAR EFFORT IS COSTING UNTOLD BILLIONS OF

DOLLARS, YET WE DO NOT COUNT THE COST BECAUSE WE WANT THEM TO HAVE EVERYTHING THEY NEED TO DO THE JOB RIGHT.

AFTER THE JOB IS DONE, WILL THE COST OF A FEW BILLION DOLLARS MORE BE TOO MUCH FOR A GRATEFUL NATION? WILL THE NATION BE WILLING TO FOOT THE BILL TO HELP VETERANS RECOVER FROM THE HORRORS OF COMBAT, MEND BROKEN BODIES, FIND JOBS, AND GET MORE EDUCATION, TO NAME JUST A FEW OF THE THINGS WE KNOW THEY WILL NEED? WILL ALL THIS BE AT THE EXPENSE OF VETERANS OF PAST WARS?

IF ANY LESSONS WERE LEARNED FROM VIETNAM AND ITS AFTERMATH, PAST MISTAKES WILL BE AVOIDED. SO FAR IN THE CONDUCT OF THE WAR ITSELF, PAST MISTAKES ARE APPARENTLY BEING AVOIDED. HOPEFULLY, THAT WILL CONTINUE, EVEN AFTER THE SHOOTING STOPS.

CONGRESS AND THE ADMINISTRATION NEED TO PROGRESS WELL BEYOND CURRENT SERVICES BUDGETS FOR THE VA. I CERTAINLY ECHO YOUR EXPRESSION OF SUPPORT FOR THE VA MR. CHAIRMAN, AND WILL WORK WITH YOU AND OUR COMMITTEE MEMBERS TO MAKE IMPROVEMENTS WHERE WE CAN.

THANK YOU MR. CHAIRMAN.

REP. CHRIS SMITH, NJ

VETERANS AFFAIRS COMMITTEE HEARING ON

VA FISCAL YEAR 1992 BUDGET

FEBRUARY 20, 1991

Thank you, Mr. Chairman.

Mr. Chairman, I appreciate your arranging this hearing today to review the Administration's fiscal year 1992 VA budget proposal.

It appears as though the VA has proposed a significant increase in funding -- almost a $1 billion increase over last year's figures. The reality is, however, that demands for increased funding exceed the amount budgeted for fiscal year 1992. The amounts proposed to carry the VA through the next year will allow us to barely maintain current services -- services which we all know are in true need of improvement.

We are all aware of the necessity to restrain federal spending -- we all worked through last year's budget debates and struggled with proposals for across-the-board cuts in various federal programs. I hope that this year we can come up with some innovative ways to efficiently deliver quality services to veterans so that costs can be contained without adversely affecting veterans' benefits.

I commend the efforts of the Secretary of the Department of Veterans Affairs, Edward Derwinski, who has consistently attempted to secure for his Department funding levels capable of providing vetreans the services they deserve. Indeed, there have been significant improvements in VA's budgets these past two years.

I welcome our witnesses here today and look forward to hearing their testimonies.

THE HONORABLE MICHAEL BILIRAKIS
COMMITTEE ON VETERANS AFFAIRS
FEBRUARY 20, 1991

MR. CHAIRMAN, I REALIZE WE HAVE A GREAT DEAL OF MATERIAL TO DISCUSS TODAY SO I WILL KEEP MY REMARKS BRIEF. HOWEVER, I WOULD LIKE TO SAY THAT I LOOK FORWARD TO WORKING WITH YOU, MR. STUMP, THE RANKING MINORITY MEMBER, THE OTHER MEMBERS OF THE COMMITTEE, AND SECRETARY DERWINSKI AND HIS STAFF IN 102ND CONGRESS.

I AM PLEASED THAT THE FULL COMMITTEE IS MEETING TODAY AND TOMORROW TO REVIEW THE ADMINISTRATION'S 1992 BUDGET PROPOSAL FOR THE DEPARTMENT OF VETERANS AFFAIRS, AND I AM ANXIOUS TO HEAR SECRETARY DERWINSKI'S TESTIMONY.

THE DEPARTMENT FACED THE MONSTROUS TASK OF DESIGNING A BUDGET REQUEST FOR THE VA SYSTEM AND I COMMEND THE SECRETARY FOR HIS ATTEMPTS TO PROTECT FUNDING FOR VETERANS BENEFITS. UNFORTUNATELY, THE PROPOSAL RELEASED BY THE OFFICE OF MANAGEMENT AND BUDGET BARELY ALLOWS THE VA TO TREAD WATER.

SEVERAL ASPECTS OF THE ADMINISTRATION'S PROPOSAL CONCERN ME. FIRST, THE BUDGET MAKES FEW, IF ANY ATTEMPTS TO TAKE INTO ACCOUNT THE CONSEQUENCES OF OPERATION DESERT STORM.

WE HAVE ALL HEARD STORIES OF VETERANS BEING TURNED AWAY FROM THE VA. HOW CAN THE VA HOPE TO MEET THE ADDITIONAL BURDEN OF DELIVERING CARE FOR SOLDIERS WOUNDED IN THE MIDDLE EAST IF IT LACKS THE RESOURCES TO SATISFY CURRENT DEMAND? MOREOVER, WHAT WILL HAPPEN TO VETERANS PRESENTLY IN THE VA SYSTEM?

FURTHERMORE, THE WAR IN THE PERSIAN GULF WILL CREATE NEW ELIGIBILITY FOR VETERANS BENEFITS SUCH AS VOCATIONAL AND REHABILITATION AND COUNSELING AND THE LOAN GUARANTY PROGRAM. HOWEVER, THE BUDGET PROPOSAL DOES NOT TAKE INTO ACCOUNT THE ADDITIONAL DEMANDS THIS WILL PLACE ON THE VA.

AT A TIME WHEN WE ARE EXPECTING MORE VETERANS TO ENTER THE SYSTEM, WE SHOULD BE LOOKING AT WAYS TO INCREASE AND IMPROVE THE SERVICES AVAILABLE TO THE BRAVE MEN AND WOMEN WHO HAVE SACRIFICED SO MUCH TO PROTECT OUR FREEDOM.

SECONDLY, SEVERAL SECTORS OF THE VA CONTINUE TO BE NEGLECTED. FOR INSTANCE, THE ADMINISTRATION REQUESTED AN INCREASE OF $3.5 MILLION FOR THE NATIONAL CEMETERY SYSTEM (NSC) WHILE AT THE SAME TIME PROPOSING A REDUCTION OF 37 FULL TIME EQUIVALENT EMPLOYEES. AS OUR VETERAN POPULATION AGES, INTERMENTS AND THE NUMBER OF GRAVESITES WHICH MUST BE MAINTAINED WILL CONTINUE TO RISE. THE BUDGET DOES NOT ALLOW FOR ANY EXPANSION OF THE NCS.

THE AREA OF MEDICAL AND PROSTHETIC RESEARCH PROGRAM IS ANOTHER EXAMPLE. THE BUDGET IDENTIFIES R&D IS THIS FIELD AS SERVING THREE GOALS: TO ENHANCE RECRUITMENT AND RETENTION OF HIGH QUALITY ACADEMIC PHYSICIANS; TO PRODUCE NEW KNOWLEDGE REGARDING DISEASE, PREVENTION, TREATMENT, AND REHABILITATION; AND TO DISCOVER WAYS TO ASSIST VA IN EFFICIENTLY ORGANIZING AND PROVIDING HEALTH SERVICES. HOWEVER, THE PROPOSAL DOES NOT INCLUDE ANY INCREASED FUNDING FOR THIS VALUABLE RESEARCH.

THIRD, THE BUDGET CALLS FOR AN INCREASE OF APPROXIMATELY $1 BILLION FOR THE VA HEALTH CARE SYSTEM. UNFORTUNATELY, THIS SIGNIFICANT INCREASE WILL BE SEVERELY ERODED BY INFLATION AND RISING PAYROLL OBLIGATIONS. THE PROPOSED ENHANCEMENT EVAPORATES BEFORE IT EVEN REACHES THE VETERAN.

I HAVE NEVER BELIEVED THAT "COST" IS A TERM WHICH SHOULD APPLY TO EXPENDITURES ON VETERANS PROGRAMS. DELAYING PROJECTS SUCH AS THE MODERNIZATION OF VA MEDICAL FACILITIES MIGHT SAVE MONEY TODAY, BUT SUCH PROCRASTINATION MAY PROVE TO BE VERY EXPENSIVE IN THE LONG RUN.

ALTHOUGH THIS BUDGET PROPOSAL IS AN IMPROVEMENT OVER THOSE PRESENTED TO THIS COMMITTEE IN THE PAST, I DO NOT BELIEVE IT ADEQUATELY MEETS THE NEEDS OF THE NATION'S VETERANS.

THE MEN AND WOMEN WHO HAVE SERVED IN OUR ARMED FORCES MET THEIR OBLIGATIONS TO THE COUNTRY, BUT WE HAVE NOT FULFILLED OUR PROMISES TO THEM. NOW, MORE THAN EVER, WE NEED TO SHOW OUR VETERANS THAT THEY HAVE NOT BEEN FORGOTTEN OR ABANDONED.

STATEMENT OF THE HONORABLE TOM RIDGE
THE COMMITTEE ON VETERANS' AFFAIRS
FEBRUARY 20, 1991

Mr. Chairman and members of the Committee, although I was unable to be present at the hearing this morning because of a family emergency back in my district, I did want to express several thoughts regarding the 1992 proposed VA budget.

Let me first begin by expressing my support for and thanks to Secretary Derwinski. It goes without saying that he is committed to our nation's veterans and is doing a commendable job at the helm of caring for our nation's veterans. Although I agree that we should not let funding alone be the only testament of support for our veterans, it should be noted that the Secretary requested an additional $850 million that was not approved by OMB as part of the 1992 budget.

Although the VA budget is the largest ever proposed, I recognize that it cannot make up for the lost ground of the 1980's. Much of the increase will be absorbed by payroll costs, inflation and increased drug costs. Many areas of the VA system will suffer cuts in funding and personnel, and I am particularly concerned that the lack of resources to process claims will further erode the timeliness and quality of adjudication procedures.

Other areas of the system - major construction programs, the medical and prosthetics research program, the national cemetery system - are either funded at last year's level or will suffer a decrease in funding.

Although today's hearing provides an opportunity to scrutinize the budget, I do not want to focus solely on the negative aspects of this budget package since I am aware of several encouraging items. The Department's recognition of our aging population and its efforts to convert hospital beds to nursing home beds is a wise use of resources. Moreover, I support the VA's efforts to improve the overall delivery and quality of care in our system and look forward to the report from the VA's Committee on the Future Structure of Veterans' Health Care, which I understand will be released at the end of this fiscal year.

However, what I find most lacking in this budget is an anticipation of the costs and turmoil that may be caused by the absorption of a large number of military personnel into the VA system - whether it be for compensation, health care, or readjustment services. We already agree that the budget has placed severe constraints on funding that will only allow "business as usual." That is simply not good enough for veterans of past conflicts, nor Operation Desert Storm personnel. Although those of us on the Committee agree that we must do more, our task is now to convince those most involved with the budget process and our colleagues in the House to give priority to the VA budget.

And although the conflict in the Persian Gulf has refocused attention on our veterans, we need to see that this attention is not only revitalized during conflict. Unfortunately, during times of peace we too often forget our veterans, the sacrifice they made and the promises made to them in return for their commitment to the nation.

That renewed emphasis could not come at a better time for the VA system, and I am cautiously hopeful that as a result, veterans will gain priority in funding decisions.

Lastly, I would like to briefly touch on an issue of concern to me that I believe is not receiving the attention in the VA budget which it deserves. Post-traumatic stress disorder or PTSD afflicts over 450,000 veterans and yet only roughly ten percent are receiving care in the VA system. I believe my colleagues on this Committee and the Secretary must be aware of the reports of veterans who are experiencing recurring symptoms and flashbacks triggered by the Gulf conflict. We know that many veterans are simply not seeking or being adequately treated for PTSD, and yet it is expected that a large number of veterans will return from the Persian Gulf with this "disorder." I would strongly encourage the Secretary and members of this Committee to consider expanding treatment for PTSD by allocating greater funding and personnel.

On that note, I would like to express my support for the efforts of the Chairman and the Administration to expand VA readjustment counseling services at VA facilities to military personnel that have served in the Gulf conflict. However, I am sure it is obvious to them that it will not be possible without allocating greater resources. Presently, many veterans from past conflicts are being turned away or put on long waiting lists. We cannot expect them to step aside or assume that their problems are less important, but we must also realize that our Persian Gulf personnel will face unique problems that must be met before they snowball - as I believe PTSD did for many Vietnam veterans.

Again, let me express my regret for being unable to attend today's hearing and thank the Chairman for the opportunity to submit this statement.

Statement of Rep. Elizabeth J. Patterson
February 20, 1991

Mr. Chairman,

I regret that I have another hearing and must leave, but wish to submit a statement for the record.

Mr. Secretary, thank you and the members of your department for meeting with the Committee so that we might better understand and discuss the 1992 Budget for our veterans.

I share the concern of others that we are not including enough attention or money to the problems that will be associated with Desert Storm. One of the VA Hospitals in my state - Charleston - will be a key medical facility for any casualties that are returned stateside. We must plan ahead so that the best medical care will be there for the type of injuries that will need to be treated. Charleston has an excellent medical community and we need to begin now planning for a coordinated effort.

I look forward to working with other committee members and your staff as we make certain that our veterans are not forgotten, nor asked to take an unfair share in spending reductions.

Again, thank you for appearing before the Committee.

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Congress of the United States
House of Representatives
Washington, DC 20515
BEN JONES
4TH DISTRICT, GEORGIA

514 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4272

DISTRICT OFFICES

2938 NORTH DRUID HILLS ROAD
ATLANTA, GA 30329
(404) 728-1250

2984 EMBER DRIVE
SUITE 113
DECATUR, GA 30034
(404) 244-1513

1124 CLARK STREET
COVINGTON, GA 30209
(404) 784-0250

February 20, 1991

Mr. Chairman, I thank you for holding this hearing today. As American servicemen and women are deployed in the Persian Gulf, we must remember their needs and the needs of those who have courageously defended our freedom and liberty in previous wars. This Committee has shown its commitment to recognizing our obligation to veterans, and I am honored to be a part of it.

As a newly appointed member of the Subcommittee on Hospitals and Health Care, I am especially concerned about adequate funding for veterans' health care. With more than 78,000 veterans in the 4th District of Georgia and the Atlanta area's only VA medical center, I am aware of many of the problems and challenges confronting VA health care.

The President's budget request of $33 billion for veterans' programs represents a $1 billion increase (4.8%) over last year's request. While most of the increase will go to pay for the health care costs of our nation's veterans, it is still inadequate to meet the mounting health care needs of our country's veterans.

immediately swallowed up by existing expenses. Six hundred million dollars will go to pay for payroll costs at the VA's 172 medical centers, 344 outpatient clinics, 127 nursing home care units, 33 domiciliaries and 196 Vietnam veteran readjustment counseling centers. Inflation will take $280 million and another $100 million will be eaten up by the nationwide initiative to limit to 80 hours the work week of medical residents.

These factors, in conjunction with the fact that the VA medical system has been plagued for the last ten years with insufficient budgets, mean that the President's increase in VA health care services will do no more than maintain VA health care spending at current levels.

The budget request also contains other areas of inadequate funding. For instance, the President's budget request has no inflation increase for the GI Bill education benefits. The budget request for the VA contains no consideration for the budgetary impact of the Persian Gulf War on VA resources. Given the VA hospitals' back-up role in the Persian Gulf War, it is imperative that any budget proposal contain an analysis of the impact of Operation Desert Storm on the VA.

The President's budget request also proposes further reductions in personnel at the already understaffed National Cemetery System. Finally, the budget proposal provides no increase in VA medical and prosthetic research even after a blue ribbon panel recommended an $63 million increase. The National Institutes of Health's budget has increased by 127% in the last decade but the VA research budget has only increased by 54%.

Mr. Chairman, while being mindful of the need to reduce spending, the President's budget request fails to fulfill our government's responsibility to our veterans.

STATEMENT OF THE HONORABLE EDWARD J. DERWINSKI
SECRETARY OF VETERANS' AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
FEBRUARY 20, 1991

Mr. Chairman and Members of the Committee,

I am delighted to be here today to discuss the President's 1992 budget proposal for the Department of Veterans Affairs.

Our budget request for fiscal year 1992 is $33.2 billion. Indeed, this is the largest budget we have ever proposed. I am pleased with this level and believe it well represents our commitment and dedication to our nation's veterans.

Before I get to the specifics of our proposal, I want to address the Department's anticipated role for receiving active duty casualties as a result of Operation Desert Storm. During the past six months, VA has maintained intense contact and communication with the Department of Defense. Should circumstances dictate, VA is prepared to provide up to 25,000 beds for treatment of active duty casualties. Patients will be flown from the war zone to hub airports and further assigned to a military, VA, or community hospital depending on injury or illness.

Under 38 USC 5011, the Veterans Health Services and Research Administration is required to serve as the primary back-up to DOD medical services in a time of war or national emergency. The law provides active duty military personnel with a higher priority for medical services than all others, except service-connected veterans. We are authorized to contract with private facilities for the necessary care of veterans. I am certainly hopeful that we will not have to make these arrangements, but should the DOD require our service to provide facilities and medical care for American casualties, let me assure the Chairman and Members of the Committee that VA is ready to do its part.

Given the dedication and sacrifice that our service men and women demonstrate, it is clear that our veterans deserve the very best this nation can provide. In 1992 and beyond we plan to meet the ever changing needs of our veteran population.

The medical care budget represents an increase in funding by almost a billion dollars. This is a funding level that enables us to make improvements in patient care environments, aging veterans programs, and drug abuse treatment programs. We are adding medical personnel to facilitate these improvements. We also seek to enhance access to health care by pursuing more DOD sharing agreements.

Our construction programs directly reflect the Department's goals for patient environment improvements, as well as the need to address the seismically damaged facilities at VAMC Palo Alto.

Our older veterans have more illnesses requiring medical care. To fulfill the needs of our aging veteran population, we are focusing on increasing the number of long-term care beds. At the same time, however, we are not compromising other modalities of care. Our acute care, outpatient, and extended care systems remain strong.

Quality care for our veterans has always been a priority at VA. We are taking positive steps to guarantee that the VA system is staffed with competent and skilled professional medical personnel. To meet quality care requirements, we will establish a new external peer review system, and continue to assure proper licensing and credentialing information on VA's physicians. We will begin to meet the recent nationwide standards to restrict resident work hours, improve their supervision, and hire additional staff to relieve resident workloads. We also propose to improve recruitment and retention of health care personnel with pay reform for doctors and dentists.

We seek to enhance our program management. The Veterans Benefits Administration is implementing several management improvements with the ultimate goals of being more responsive to the needs of our clients, and improving accuracy and timeliness in the way VA conducts business. The VA is also pursuing total asset management with public/private ventures such as child care programs, office/research space, and nursing homes.

I believe, Mr. Chairman, that if we keep our house in order, our utility to veterans is all that much better. Through on-site financial reviews and financial statement audits we will promote refinement and improvement in the management of our resources. Further, to better manage our internal affairs and to improve our accountability, we are implementing a new Financial Management System.

We are again proposing to index the compensation cost-of-living allowance to the annual change in the Consumer Price Index to assure that every veteran and survivor receive their COLAs on time.

We plan to standardize Dependency and Indemnity Compensation (DIC) to allow for more equitable DIC benefits among survivors of veterans. This will not affect those already on the rolls above the standardized rate (E-6 rate). These survivors will continue to receive payments at their current levels.

The new Credit Reform law affects the operation of our housing programs, but our essential mission to facilitate the extension of mortgage credit to qualifying veterans remains unchanged.

Before Credit Reform, housing programs operated on a pay as you go basis with appropriations being requested to meet program expenses. Through a new subsidy calculation, estimates can be made to meet anticipated costs of foreclosures at the time of origination. This subsidy ensures that cash flow remains sufficient to hopefully preclude the need for appropriations.

To further reduce program costs, we are requesting legislation to make permanent the Guaranty and Indemnity fee structure. As you know, this fee structure was included in the 1990 reconciliation legislation but is only effective until September 30, 1991.

Finally, we are proposing to improve the formula used to determine whether to acquire foreclosed property. With this action, we foresee a reduction in default losses and more cost-effective property acquisitions.

I will now summarize the 1992 budget request for the VA, highlighting the budget issues for each of our major programs.

BENEFIT PROGRAMS

Compensation

The 1992 budget request is $11.2 billion to provide compensation payments to over two million veterans and over three-hundred thousand survivors. The Administration will shortly transmit a 1991 supplemental providing $303.1 million for the recently enacted 5.4 percent compensation cost-of-living adjustment (COLA) increase, effective January 1, 1991. The Administration will provide a budget amendment for an additional $632.2 million for the compensation COLA for FY 1992.

Legislation is again proposed to index compensation benefits to the annual change in the Consumer Price Index. The request proposes the first such "automatic" COLA to be effective December

1, 1991 at 5.2 percent, costing $513.6 million.

Public Law 101-508 places a limitation on the estates of incompetent veterans with no dependents. Benefit payments are discontinued when the assets of a veteran reaches $25,000. This ensures that remote heirs of incompetent veterans do not inherit large sums of a veteran's benefits. This provision of the law expires October 1, 1992. The provision is proposed to be made permanent.

Pensions

The 1992 budget request is $3.9 billion for pensions. This amount will provide payments to nearly one million eligible recipients. The 1992 caseload estimate is fifty-thousand below the 1991 estimate. This reduction reflects a declining trend in this program, which is in part due to increased mortality among eligible recipients exceeding new accessions to the rolls. Although it is anticipated that the number of veterans age sixty-five and older will increase during the 1990s, improvements in retirement benefits and income sources are expected to result in a continued decline in pension caseload.

This budget request includes the full-year impact of the 5.4 percent cost-of-living increase received by the Improved Law pension recipients in December 1990, as well as an estimated 5.2 percent cost-of-living adjustment to be effective in December 1991. By law, the cost-of-living adjustments to eligible pension recipients are based upon the actual change in the Consumer Price Index.

Legislation is proposed to extend existing law that limits monthly VA pensions to $90 for any veteran without a spouse or child who is receiving Medicaid coverage and who is in a Medicaid-approved nursing home. If extended in 1992, savings are anticipated to be $109 million in FY 1993.

The current ninety day service requirement (at least one day served during a wartime period) to receive pensions is proposed to increase to one-hundred and eighty days, all of which must be served during wartime. This would make pension eligibility consistent with other VA benefit programs. FY 1992 savings is expected to be $1.6 million.

Legislation is proposed to extend current law and make permanent the VA access to Internal Revenue Service information for the purpose of verifying the income of pension beneficiaries. This proposal is expected to save $170.9 million in FY 1993.

Burial Benefits and Miscellaneous Assistance

For FY 1992, $130.7 million is requested for the Burial Benefits and Miscellaneous Assistance program. This request provides an estimated 112,000 burial allowances to reimburse in part the burial and funeral expenses of eligible deceased veterans. A total of 122,800 burial plot allowances are requested for eligible veterans who are not buried in a national cemetery or other cemeteries under the jurisdiction of the United States. Also requested are funds for 393,700 headstones and markers, 410,500 flags, and 48,200 graveliners.

Readjustment Benefits

A total of $635.4 million is requested for the Readjustment Benefits program. This funding level provides basic benefits to over two-hundred thousand veterans and servicepersons training under the Montgomery G.I. Bill program. The basic benefits for veterans and servicepersons are enhanced with a $155 million transfer, primarily from the Department of Defense, and is used to finance benefits to veterans, reservists and servicepersons. Education benefits under the Dependents' Educational Assistance Program are also provided to thirty-eight thousand dependents.

Vocational rehabilitation is provided to over twenty-seven thousand disabled veterans.

The trainee level under the Dependents' Educational Assistance Program is estimated to be two thousand fewer in 1992 than in 1991 as more dependents complete their education. The trainee level under the new program is expected to be fifty-nine thousand higher and will continue to increase as more individuals become eligible for benefits.

Legislation is proposed to limit eligibility for Chapter 31 veterans under the Vocational Rehabilitation program. Under the proposal, benefits will only be provided to veterans rated 30 percent or higher, which is expected to save $11.2 million in 1992.

Legislation is also being proposed to limit eligibility for Survivors' and Dependents' Educational Assistance to either natural or adopted children. It is estimated that savings of $1.1 million would be realized in 1992.

Guaranty and Indemnity Fund

Since January 1, 1990, the Guaranty and Indemnity Fund (GIF) has originated all home loans in the housing program, with the exception of manufactured home loans which are still originated by Loan Guaranty. No appropriations were needed for this fund in FY 1991. For FY 1992, a total of $288.8 million in budget authority is requested for GIF, of which $74.2 million is for the liquidating account and $214.6 million is for subsidy appropriations and administrative expenses. Included in this request is $192.8 million in savings resulting from the proposed legislation outlined below. Also, in 1992, the GIF expects to originate 160,000 loans for $15.0 billion.

Under The Federal Credit Reform Act of 1990, the accounting structure for the housing program was changed to better reflect the upfront subsidy in a government loan. At the same time, no change was made to the essential mission of the housing program which is to facilitate the extension of mortgage credit to qualified veterans.

Legislation is requested to make permanent the increase in the funding fee structure established under the "Omnibus Budget Reconciliation Act of 1990". Otherwise, this fee structure would expire September 30, 1991. Savings of $88.3 million in 1992, and $382.0 million through 1996 are expected.

Legislation is requested to allow VA to include losses from resale of properties in the net value calculation when determining whether or not the loan holder can convey property to the Government. This legislation also exempts VA loans held in GNMA loan pools from the no-bid scenario. Savings of $45.5 million in 1992, and $217.0 million through 1996 are expected.

Legislation is proposed to require a 2.5 percent fee and a 10 percent downpayment for multiple use of the loan guaranty benefit. Under current law veterans can reuse this benefit provided their debt has been paid in full. This multiple use aspect ignores the fact that additional use carries nearly the same default risk. Active duty personnel will be exempt from this requirement. Savings of $59.0 million in 1992, and $261.0 million through 1996 are expected.

Loan Guaranty Revolving Fund

For FY 1992, a total of $486.5 million in budget authority is requested for the Loan Guaranty Revolving Fund, of which $277.2 million is for the liquidating account, and $209.3 million is for subsidy appropriations and administrative expenses. Included in this request is $100 million in savings resulting from the proposed legislation outlined below. This fund continues to provide operational support for loans closed prior to January 1, 1990, as well as guarantees on manufactured home loans.

Legislation is proposed to allow the net value calculation and GNMA exemption under the Guaranty and Indemnity Fund to also apply in computations pertinent to this fund. Expected savings are $101.4 million in 1992, and $243.3 million through 1996.

Legislation is proposed to merge the Direct Loan Fund with the Loan Guaranty Fund. Because of the low level of activity in the Direct Loan Fund, it is no longer financially prudent to have a separate fund for direct loans. Savings in "outlays" are expected to be $5.8 million in 1992, and $17.0 million through 1996.

Finally, legislation is proposed to increase the funding fee on manufactured home loans from 1 to 2 percent and require a 10 percent downpayment.

MEDICAL PROGRAMS

Medical Care

The FY 1992 budget request of $13.3 billion for direct medical care is approximately $1.0 billion above the 1991 level. These resources add 1,476 VA medical personnel, which increases the average employment level to 196,114.

The resources requested will allow VA to provide health care to the projected number of eligible veterans expected to apply for care on a system-wide basis. This budget request supports care for approximately 1.2 million inpatients treated and 23.6 million outpatient visits.

The budget request supports quality health care by funding physician and dentist special pay at $41.5 million, and by providing funds for additional staff to relieve resident workloads. The budget also provides resources to curtail the effects of inflation and fund staffing requirements associated with the opening of new facilities. Further, the budget proposes to reform beneficiary travel for a savings of $62.9 million.

Funding is proposed for one additional Geriatric Research Education and Clinical Center bringing the total number of units to 16. Drug abuse treatment increases by $15 million and 195 FTE. Resources of $6.6 million and 135 FTE are requested to bring the conversion to automated unit dose to 83 percent of all VA beds.

To meet the demands of the aging veteran population, the budget requests funding for 1,863 new and converted nursing home care beds to become operational in FY 1992. Also requested is funding for an additional 1,808 new and converted nursing home care beds for future operation.

Other significant legislative proposals affecting hospital care are to permanently continue the copayments authorize by the "Omnibus Budget Reconciliation Act of 1990," and to authorize means tested copayments from service-connected veterans rated 40 percent or less disabled for nonservice-connected conditions. Collections anticipated as result of these proposals are estimated to be $125 million.

Medical Care Cost Recovery

For FY 1992, a total of $60 million and 1,578 FTE are proposed to process all billings and collections related to the medical treatment of veterans. This includes processing billings and collections for third party insurance, copayments and prescription fees. The return on this investment is expected to be $574 million in FY 1992.

Medical and Prosthetic Research

The 1992 budget request for Medical and Prosthetic Research is $216.8 million and 3,916 FTEE. This funding level is unchanged from 1991. The overall policy governing the President's goal of the FY 1992 budget is to meet the requirements for deficit reduction established by the 1990 reconciliation legislation. As a result, only a few of our highest priority program increases can be requested. Although medical research is an important priority, increases for direct medical care for veterans take precedence.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

The 1992 request for MAMOE is $40.5 million and 521 FTEE, reflecting a decrease of $955 thousand and 7 FTEE from the 1991 appropriation level. After adjusting the 1991 level for the non-recurring needs of the Commission on the Future Structure of Veterans Health Care, the Medical Administration request for 1992 reflects an increase of $1.9 million above the 1991 level.

Health Professional Scholarship Program

The 1992 appropriation request is $10.1 million, the same level as 1991. Prior to 1991, this program was part of MAMOE.

Grants for Construction of State Extended Care Facilities

The 1992 budget request of $85 million is an increase of $15 million over the 1991 level. This funding will continue VA's policy of providing additional VA-sponsored nursing home beds through less costly State programs. These resources will provide 926 additional nursing home beds and 250 domiciliary beds.

GENERAL OPERATING EXPENSES

A total of $847.2 million is requested for the General Operating Expenses (GOE) appropriation in 1992. This funding level, together with the $128.2 million of administrative costs associated with VA's credit programs that will now be funded in the entitlement accounts per Credit Reform provisions, will provide $975.4 million for operations under the GOE account. This funding level is $73 million or 8.1 percent above the 1991 funding level. Requested resources will support an average employment of 17,321.

Veterans Benefits Administration

The 1992 budget request for the Veterans Benefits Administration (VBA) is $572.6 million with an average employment level of 13,140. This request, combined with the $128.2 million, associated with Credit Reform and funded in the entitlement accounts, is $84 million above the 1991 level and average employment increases by 33.

Reflected in VBA's request is $27.6 million associated with the transfer of 356 FTEE from the General Administration account to VBA. This transfer effects the realignment of data processing centers so that management for day-to-day operations of the computer centers will be under the responsible program area.

The budget request also provides for the implementation of certain cost reduction measures mandated by the "Omnibus Budget Reconciliation Act of 1990". VBA administration expenses will be reimbursed from the Compensation and Pensions appropriation for costs estimated at $9.7 million in 1992 for this implementation.

The 1992 request included $42.0 million for the first stage of VBA's modernization of its Benefits Delivery Network. This stage will enable VBA to produce the necessary equipment and services to establish a more modern processing environment within the regional offices. This effort will result in long-term efficiencies for VBA and enhance the quality and timeliness of claims processing and benefits delivery to the veteran population.

To add to the modernization effort, VBA will continue to expand training at the adjudication academy. The academy will emphasize higher quality work and enhanced timeliness and will expand to include training for rating specialists and senior adjudicators as well as entry level adjudicators.

Efforts will continue to be concentrated on improved servicing of delinquent GI and portfolio loans, as well as monitoring lenders through the Lender Monitoring Unit. During 1992 VBA plans to add 10 FTEE to this unit to expand the scope of reviews to include lender servicing activities, and implement a loan default prediction model which will assist VA in identifying potential high loan losses.

National Cemetery System

The 1992 budget request for the National Cemetery System of $57 million and 1200 FTEE is $3.5 million above and 37 FTEE below the 1991 level. The budget request provides resources for the interment of 64,000 veterans and their dependents and the maintenance of over 1.9 million gravesite and 5,127 developed acres. A funding level of $5.1 million is also requested for the continuation of the state cemetery grant program in 1992.

General Administration

The General Administration 1992 request of $217.6 million and 2,981 FTEE is a $14.7 million and 527 FTEE decrease below the 1991 level. Encompassed in this reduction is the transfer of 356 FTEE and $27.6 million to VBA for the realignment of data processing centers. Additionally, the General Administration activity includes $1.6 million for a Survey of Veterans (SOV IV) in addition to funding studies related to the 1990 Census. This initiative was deferred from 1991 due to funding constraints.

Office of the General Counsel

The Office of the General Counsel continues to dedicate an increasing level of resources to support additional legal representation requirements resulting from Judicial Review as well as expanding efforts in the area of medical care cost recovery.

Financial Management System

The budget request is $10.2 million for the continued development of a modern, integrated Financial Management System (FMS). The Administration considers replacement of obsolescent, inadequate financial networks as a high priority.

Office of Inspector General

The Office of Inspector General requests nearly $30 million and 417 FTEE in 1992. This is a $5 million (20 percent) and 12 FTEE increase over 1991 resource levels. Additional funding will provide for audited financial statements and continue to place high priority on monitoring and evaluating VA's medical care quality assurance programs.

CONSTRUCTION PROGRAMS

A total of $654.2 million is requested in budget authority for all construction activities at VA facilities in fiscal year 1992. The budget request enhances our priorities of improving patient care environments, increasing funding for long-term care, as well as correcting deficiencies in existing facilities. A substantial portion of the total, $253.8 million, is requested for essential patient care environment improvement projects.

Major Construction

The major construction budget request is $450.0 million, which includes construction activities at medical centers, regional offices and national cemeteries.

The budget request provides funding for seismic corrections at VAMC Palo Alto as a result of the damage caused by the October 1989 Loma Prieta earthquake. A total of $40.0 million is requested for Phase I, to build the steel structure for the new 250-bed acute care hospital, at Palo Alto (Palo Alto Division), CA. Further, $3.5 million is proposed for the construction design of five seismically sound therapeutic units at the Palo Alto (Menlo Park Division) Medical Center, CA.

Significant new patient environment improvement projects include: $45.8 million for a geropsychiatric facility at Marion, IN; $39.0 million for a psychiatric and outpatient clinic at Northport, NY; and $41.6 million for a psychiatric building at Tuscaloosa, AL.

For primary modernization and replacement projects, $60.9 million is requested for phase II of the North Chicago VA medical center, and $6.3 million is proposed for the design of a clinical addition and parking garage at Tampa, FL.

Funding to construct a $44.2 million ambulatory care outpatient addition in Brooklyn (Brooklyn Division), NY, is requested, as well as funding to construct a new $30.8 million spinal cord injury center and energy plant at Dallas, TX. A total of $11.5 million is requested for nursing home care renovation for 120 new beds in Salisbury, NC, and $14.8 million is proposed for a domiciliary replacement at Bonham, TX.

A total of $13.7 million is requested to expand the Riverside National Cemetery, CA, to allow it to remain open for at least 10 more years.

Funds totalling $43.3 million are requested for the regional office program for improved operating economies and services to veterans. At two locations, Houston, TX, and St. Petersburg, FL, regional offices will be relocated onto medical center grounds.

Environmental safety concerns are targeted in the budget where $7.2 million is sought to remove asbestos in Department-owned buildings, and $2.0 million is requested for the cleanup of hazardous waste.

Minor Construction

The request for the minor construction program is $195.7 million, which is an approximately 50 percent increase over 1991. With attention to improving patient environment and long-term care, this level of funding for this appropriation is considered essential. One of our highest priorities was achieved with a funding request of $19.0 million for minor construction nursing home care, which is a significant increase over the FY 1991 level of $1.5 million. Minor construction includes a General Administration limitation of $46.2 million.

CLOSING

Mr. Chairman, in closing, we are committed to the accomplishment of the VA's mission to provide veterans the care, support and recognition they have earned in service to this Nation. Our budget request reflects this commitment. This concludes my introductory statement. My staff and I will be pleased to discuss the details of this request and answer your questions and those of the Committee Members.

Statement of Thomas E. Collins
Assistant Secretary for
Veterans' Employment and Training
Before the
Committee on Veterans' Affairs
U.S. House of Representatives

February 20, 1991

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to appear before you as Assistant Secretary for Veterans' Employment and Training to present the Fiscal Year 1992 Department of Labor budget as it pertains to veterans' employment and training programs.

With several weeks of the Persian Gulf war as a background, I would like to discuss our FY 1992 budget plans. We are requesting a total of $129.187 million for FY 1992 to fund 288 Federal positions and 1,930 State positions by the end of that fiscal year. Comprised of $109.133 million for grants-to-States and $20.054 million for administration, those funds represent certain changes from the FY 1991 budget. This budget contains two significant funding reductions and one major initiative in the VETS program -- a reduction of $42,260,000 for the Disabled Veterans' Outreach Program (DVOP), which represents the impact of the sunset of certain provisions in the DVOP program, a reduction of $2,440,000 which reflects elimination of the centralized National Veterans' Training Institute, and an increase of $1,827,000 for expansion of the Transition Assistance Program (TAP).

With respect to the Disabled Veterans' Outreach Program (DVOP), under existing law, funding is to be provided for one DVOP specialist for each 5,300 disabled and Vietnam-era veterans residing in each State. However, that statute also removes Vietnam-era veterans from receiving special emphasis in certain Department of Labor programs, including DVOP, effective December 31, 1991. This reduces the number of DVOP positions to be funded under the formula from 1,885 to 438, a 77% reduction after that date. As a result the funding request for DVOP is $34,910,000 for FY 1992.

A decrease of this magnitude requires a narrowing of the mission of the 438 remaining DVOP staff so that they provide only outreach services and only to disabled veterans. Outreach services will consist of seeking out newly separated disabled veterans, conducting job development visits and promotional activities with employers to generate employment and training opportunities for disabled veterans, and locating disabled veterans who have been in need of assistance for longer periods.

This budget request does not reflect the potential impact of Operation Desert Storm, and if it becomes necessary, the Administration is willing to work with Congress to establish a more realistic staffing formula.

The Local Veterans' Employment Representative (LVER) program is also one of the primary grants-to-States programs administered through VETS. This budget submission requests an increase in funding from $71,095,000 to $74,223,000 to support 1,492 LVER staff. This represents an increase of 4.4% over the FY 1991 appropriation level and allows LVERs to perform all duties required by statute. Involvement of some LVERs in the delivery of the Transition Assistance Program will be required.

In regard to the National Veterans' Training Institute (NVTI), by the end of FY 1991 nearly all DVOP and LVER staff (the primary recipients of NVTI training) will have been trained in the Professional Skills course, greatly reducing the need for a centralized institute in FY 1992. In addition, most of the Veterans' Employment and Training Service (VETS) staff who require Veterans' Reemployment Rights training will have received NVTI training by the end of FY 1991. Because of the current serious budget constraints and projected DVOP staffing levels for FY 1992, there will be very little influx of new State and Federal staff to be trained through NVTI. In the existing climate of severe budget austerity, the maintenance and operation of a centralized training institute with its associated staff and overhead costs is not the most cost-effective vehicle to meet those decreasing training needs. Therefore, no funds are requested for NVTI for FY 1992.

This budget request includes $20.054 million for administration to support 288 positions for the agency with no additional staffing requested. This level is an increase of 16.7% from the $17.18 million provided for FY 1991 which enables funding of the Transition Assistance Program as described later. VETS staff have experienced a significant number of requests for Veterans' Reemployment Rights (VRR) technical assistance from both employers and members of the Reserves and National Guard due to Operation Desert Storm. We anticipate a significant increase in the VRR workload due to the return of veterans, reservists and National Guard members due to Desert Storm. Staff levels for VRR will remain unchanged, but special emphasis will be placed upon serving those returning servicemembers to ensure that timely and effective assistance is provided. We intend to demonstrate our commitment to protect the reemployment rights of those who sacrificed so much to serve during Operation Desert Storm. Concurrently, it is expected that the agency will continue its expanded public relations/technical assistance campaign in order to facilitate each veterans' return to the civilian workforce and minimize the number of VRR complaints filed. In addition, VETS will streamline policies and operational procedures for the VRR program resulting from legislative changes. This request level provides adequate funds for travel for monitoring, evaluation and technical assistance by VETS field staff.

The only new program included in the administration portion of this budget is the request for increased funding for the Transition Assistance Program (TAP) from $225,000 for FY 1991 to $2,052,000 for FY 1992. TAP was established in 1990 as a pilot program authorized by the Veterans' Benefits Amendments of 1989 (P.L. 101-237). During FY 1991 the TAP pilot program will conduct 248 workshops providing assistance to 9,176 participants. Enacted on November 5, 1990, the National Defense Authorization Act for FY 1991 (P.L. 101-510) authorized TAP expansion from the pilot stage to a nationwide program. The request level for FY 1992 will permit expansion of TAP to be operational in the 36 States in which over 90 percent of separations occur: 800 workshops will be conducted to provide assistance to about 60,000 participants. The TAP workshops will be staffed by contract facilitators, Department of Defense civilian staff, and State Employment Service personnel such as LVER staff. Workshops will provide separating servicemembers with job finding assistance and labor market information within 180 days prior to their separation from active duty, using workshop materials produced by VETS. Training of workshop faculty will also be a responsibility of VETS. Interagency cooperation will be carried out according to the Memorandum of Understanding implemented on January 2, 1991, by the Departments of Labor, Defense and Veterans Affairs, the agencies which jointly administer TAP. A program evaluation of TAP is scheduled for completion in May 1992 to help determine program value and optimal design.

This budget does not include the grant programs administered by this agency under Title IV, Part C of the Job Training Partnership Act (JTPA), nor the Homeless Veterans' Reintegration Program (HVRP) under the Stewart B. McKinney Act. Resources for all JTPA programs, including Title IV, Part C, are appropriated through the Training and Employment Services account of the Employment and Training Administration. Beginning in FY 1992, most homeless programs, including HVRP and others administered by the Department of Labor, will be consolidated under the Department of Housing and Urban Development (HUD). Therefore, no funding is requested for HVRP for FY 1992.

The JTPA Title IV, Part C, program is administered by this agency and generates a substantial portion of our workload. The grants management staff develops grant processing procedures, establishes and maintains the grant review and evaluation process, and coordinates the funding of all of the grants awarded. Our share of JTPA for Title IV, Part C, is $8,792,000 for FY 1992, according to the formula in the JTPA statute. At that funding level, it is anticipated that 5,099 eligible veterans will be served, of whom 3,060 will be placed in unsubsidized employment at a cost of $2,873 per placement.

Thank you once more for this opportunity to discuss the Veterans' Employment and Training Service's budget. I will be pleased to answer your questions.

WITNESSES FROM
UNITED STATES COURT OF VETERANS APPEALS

FOR HEARING BEFORE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

ON

BUDGET RECOMMENDATIONS FOR
VETERANS' BENEFITS AND SERVICES

February 20, 1991, 9:00 a.m.

Honorable Kenneth B. Kramer	Associate Judge
Honorable John J. Farley, III	Associate Judge
Ms. Deborah Creek	Budget Officer

FOR RELEASE ON DELIVERY
Expected at 9:00 A.M. EST
February 20, 1991

STATEMENT OF
HONORABLE FRANK Q. NEBEKER
CHIEF JUDGE, UNITED STATES COURT OF VETERANS APPEALS
FOR PRESENTATION BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
FEBRUARY 20, 1991

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

On behalf of the Court, I appreciate the invitation to present for your consideration the fiscal year 1992 budget for the United States Court of Veterans Appeals. The Court is relatively new and, thanks to the continuing support of this Committee and others in the Congress, has been able to establish most of its administrative programs and begin to issue decisions. The Court has completed its first full fiscal year, having been in operation since October 1989. From October 1989 through July 1990, the Court operated with only three of its seven authorized judgeships filled. Of the four remaining judgeships, three were filled in August 1990 and the fourth in September 1990.

During the past year, the Court has focused on significant legal issues which will shape the jurisprudence of the Court for years to come. Copies of these seminal decisions have been provided to the Committee on a regular basis and have been reported widely in the veterans' media. The Court has made substantial progress in establishing its judicial processes and administrative programs. Notably, the Court appointed an Ad Hoc Rules Committee and issued the Interim General Rules of the Court. A Rules Advisory Committee was created to review public comments on the Interim General Rules, and to develop recommendations for the final General Rules. The Court published its proposed final Rules of Practice and Procedure on February 13, 1991.

While a more definitive listing of the Court's administrative accomplishments is included in its fiscal year 1992 budget submission, the following are among its most significant: Execution of the appointments of the Court's four remaining associate judges; the final planning and accomplishment of the design and buildout of the Court's permanent office location, and the move of the Court to its new facility; the establishment and initial stocking of the Court's central library; the execution of a contract for a 5-year task plan to evaluate the Court's automated functional requirements and to provide automated processing systems; the completion of the first actuarial study for the Court's retirement system; and the establishment of an Admissions Committee to develop and implement procedures for screening practitioner applications.

In fiscal year 1992, the Court anticipates several significant program-related changes. These include:

- Expansion of the Court's security arrangement, based on the initial recommendations of the U.S. Marshals Service, to provide adequate protection of the Court's new permanent facility. A total of five Court Security Officers (CSOs) is recommended to provide security on a daily basis, and the Court must fund all costs associated with this program. An additional $125,000 will be needed for three more CSOs, one of whom was hired in January 1991 on an emergency basis, to enhance security pending approval of permanent funding.

- The reduction of the Court's travel and transportation costs from $160,000 to $100,000, as a result of its decision to postpone the conduct of hearings outside Washington, D.C., until a sufficient statistical basis is developed to project adequately the need for hearings by geographical region.

- Expansion of the Court's ability to support the legal research needs of its judges, the judicial staff, and central legal staff for computer-assisted legal research. An additional $145,000 is needed to support access to WestLaw and Lexis, and to provide access to other computer-assisted legal research tools similar to those which the Department of Veterans Affairs, the appellee in all of the Court's cases, makes available to its appellate legal staff.

- Reduction of the funding needed to support the Court's admissions committee from $100,000 to $25,000, and the approval of an additional $45,000 in funding to support the inception of a Judicial Conference for the Court. The reduction in funding results from the committee completing its initial work of reviewing the Court's admissions and related needs. Further work is needed on establishing standards for admissions and the procedures for reviewing applications. Regarding the Judicial Conference, the Court proposes to develop and inaugurate an annual Judicial Conference program to provide the judges, other Court personnel, and the bar with a periodic and structured opportunity to meet and discuss salient legal issues and various Court operational matters. The first conference would be held next year.

The Court did not reach its full complement of judges until late in the last fiscal year. This fact, plus the inherent difficulty in projecting statistical trends without established benchmarks, makes caseload projections very tentative. However, the statistics for one recent month may assist the Committee by providing a snapshot of Court operations. In January 1991, the Court received 179 new cases. In addition, 307 motions were filed, 610 orders were issued, and there were dispositions in 28 cases. The Court will continue to monitor trends in our caseload both to gauge and project the Court's overall workload. The

Court will keep this Committee and other pertinent Congressional Committees advised as the Court's longer-term trends become apparent.

Under the procedural time periods established by the Court's Interim General Rules of Practice, in the best of all worlds a case would progress from filing to a judge for initial review in 156 days. I must hasten to add that virtually no case moves at the pace established by the time periods in the Court rules. In many instances, there are case-related legal subissues that must be resolved by orders, sometimes after motion and reply, and there must always be additional time allotted for the Court to conduct its legal analysis and procedural process. However, under the Court's recently released Rules of Practice and Procedure, which are scheduled to become effective on March 29, 1991, assuming the parties closely adhere to the established procedural time requirements and that there are no side issues requiring resolution, a case could move through the procedural process and be submitted to a judge for review within 180 days.

Cases in which the appellant is unrepresented have virtually no prospect of moving according to those time lines, and therein lies a major problem. The Court has experienced a fairly consistent increase in the number of cases filed by unrepresented appellants who are unfamiliar with the judicial process in general and with Court procedures in particular. Currently, 64 percent of all case filings are by unrepresented appellants. The Court has no available mechanism for appointing or paying counsel. Unrepresented appeals must be resolved with the same vigor and fairness as are represented cases, but many of these unrepresented appeals are handwritten, intemperate, and difficult to understand. As a result, almost two-thirds of our cases require the use of substantial additional staff resources and attention to prepare the case properly for initial review by a judge. Again, the Court will advise the Congressional Committees as more information becomes available.

In conclusion, I appreciate this opportunity to present the Court's budget request for fiscal year 1992 and want to express my gratitude again, and that of all the Court's judges, officers, and employees, for this Committee's support. We will be happy to answer any questions the Committee may have regarding the Court's budgetary and appropriation needs.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

Chairman Montgomery to Department of Veterans Affairs

CONGRESSMAN MONTGOMERY

Question: 1. In prior fiscal years, VA Medical Center Directors found it necessary to divert monies from equipment and other accounts to meet operating costs. Which discretionary accounts currently face a potential reduction in funds due to "reprogramming" in order to enable medical center directors to meet operating costs? Which discretionary accounts have been shielded from such "reprogramming" through Central Office directives?

Answer: VA Medical Centers were provided the opportunity to plan for their operations within their budgets and essentially without restrictions on discretionary accounts. The aggregation of these local plans indicates that medical care employment will be at the levels desired by Congress. Operating costs are appropriately covered in these plans. As a single exception, the medical centers have been directed to assure that funds planned for prosthetics supplies and repairs are used for that purpose only.

Question: 2. It is my understanding that the department asked for $700 million in major construction funding for fiscal year 1992 but received only $450 million. In light of the enormous difference in those figures, what impact will the proposed funding level have for fiscal year 1992 and for the succeeding fiscal years?

Answer: The Department believes that within the context of the limited resources available, the funding levels for major construction is adequate. Although the request to OMB was larger, most of the difference is in the adjustment for Palo Alto, which we accommodated by including funding for the structural steel, thus not delaying the project.

Significant increases in the minor program as well as in the nonrecurring maintenance program reflect a shift toward seeking facility improvements where possible with less costly solutions.

Question: 3. To what extent are new DHCP initiatives, such as clinical support for physicians and dentists, reflected in the FY 1992 budget request? In the budget documents DHCP is described as "essential for effective management of a health care delivery system." It is my understanding that a large increase in equipment purchases was initially recommended. Why then did this program receive a $10 million cut in needed equipment, especially in light of the $31 million cut recommended in the FY 91 budget?

Answer: There are no new DHCP initiatives in the FY 1992 budget. DHCP remains a high priority in the VA, and the VHS&RA Strategic Information Systems Plan (SISP) states that "Applications that integrate patient data for clinical care are the highest priority." In support of the SISP, VHS&RA developed 15 proposed Clinical Practice Extensions (CPE) to extend the benefits of DHCP to additional clinicians and clinical specialties and to provide additional support in key areas, including nursing. Based on available dollars only the highest priority initiatives were requested in the FY 1992 budget.

Question: 4. In FY 91, staffing and funding for Third Party collections were absorbed in the medical care accounts. Now that the administration of these functions will be carried out through the medical care cost recovery account, why does the budget propose to reduce the medical care account by the 500 FTE who were initially shifted to perform Third Party collections

Answer: Public Law 99-272, the Veterans Health Care Amendments Act of 1986, gave the VA authority to bill health insurance companies for health care provided to non-service connected veterans who had private health insurance. Since that Act became law, certain employees were given the responsibility for the administration of this billing activity in Medical Care.

Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990, provided for the establishment of a separate fund for collections from health insurance companies for health care provided to non-service-connected veterans. This fund (Medical Care Cost Recovery (MCCR)) supported the cost of collections. Therefore, the 500 FTE originally identified with the administrative support of this program in Medical care will be supported within the MCCR account. As a result, the Medical Care appropriation can be reduced 500 FTE and $20.2 million.

Question: 5. The Department's FY 1992 budget submission identifies a "savings" of $70 million due to a workload shift from hospital care to outpatient care. Is this a paper savings or will it be available for redirection to other Medical Care functions?

Answer: This management initiative recognizes that workload has been shifting from inpatient to outpatient care and that this trend is expected to continue in 1992. Treating patients in an outpatient care setting is less costly than inpatient care. The use of outpatient care instead of inpatient care will occur where medically appropriate and consistent with desired outcomes.

VHS&RA estimates that a shift from inpatient to outpatient care would produce a decrease of 10,959 hospital inpatients treated while generating an additional 92,000 outpatient visits. Based upon projected costs per patient treated and staffing ratios, inpatient resources were estimated to decrease by $82.7 million and 1,348 FTE while additional outpatient visits will require $12.7 million and 170 FTE. The shift, therefore, results in a net decrease of $70 million and 1,178 FTE. The net savings were used to allow VHS&RA to include medical program initiatives that could not otherwise have been supported within the requested level.

Question: 6. To what extent do the proposed construction accounts support the workload shift from inpatient to outpatient care?

Answer: Current medical practice patterns reflect a greater reliance on the use of outpatient care than inpatient care when medically appropriate. Likewise a greater emphasis has been placed on outpatient care in Construction planning for replacement/modernization projects, clinical improvements, and outpatient additions. For example, roughly 20% of the major construction dollars in the FY 1992 budget are for outpatient care. In addition, new and expanded satellite, community-based, outreach, rural and mobile clinics have been activated through leasing to accommodate projected outpatient workload. From 1982 to 1992 outpatient workload has increased at an average annual rate of 3.9 percent. VHS&RA estimates that projected outpatient capacity in 1992 will accommodate the .4 percent increase in visits associated with the anticipated shift from inpatient to outpatient care.

Question: 7. The overall workload figures indicate no change in anticipated inpatient workload levels. How can the Department maintain its current inpatient workload level given existing staffing and funding shortages as well as the redirection of $70 million and approximately 1,200 FTE from inpatient to outpatient care?

Answer: Although the level of VA hospital workload is expected to remain stable in 1992, several factors influence patients treated.

Workload has been shifting from inpatient to outpatient care, and this trend is expected to continue in 1992. Treating patients in an outpatient care setting is recognized as more cost effective than inpatient care. The use of outpatient care instead of inpatient care will occur where medically appropriate and consistent with desired outcomes. The planned workload shift will result in a reduction of 10,959 inpatients treated and an increase of 92,000 staff outpatient visits. Further reductions to patients treated are expected due to the conversion of inpatient hospital beds to nursing home care beds (-343 hospital patients treated). Additions to inpatient workload are associated with facility activations (+6,072 patients treated), the drug abuse treatment initiative (+2,558 patients treated) and a calendar day change (+2,672 patients treated). The net effect of all these factors is no change to hospital patients treated. However, each factor is fully supported in the budget request with appropriate staffing and funding.

Question: 8. It appears that some special programs such as alcohol treatment and PTSD have received increases in funding. Are these increases mainly inflation adjustments or do you anticipate that the additional funds will provide for an increase in workload within these programs?

Answer: The increase in the Alcohol and Drug Dependence Treatment program reflects adjustments for inflation and a request of $15 million for drug abuse treatment. Through its network of substance abuse treatment programs, VA is one of the largest providers of substance abuse treatment services in the country. These additional resources are requested to support the following programs: inpatient drug treatment, outpatient drug treatment, inpatient dual diagnosis, outpatient dual diagnosis, and domiciliary drug treatment and, physician fellowship and interdisciplinary training programs in substance abuse. These resources will support an additional 2,558 patients treated and 182,000 outpatient visits.

VA's budget reflects a commitment to maintain the current level of treatment services that exist or are being activated in FY 1991 for PTSD. This consists of a network of specialized PTSD programs supporting PTSD treatment in general psychiatry inpatient and outpatient programs across the VA medical care system.

Question: 9. What impact, if any, will this budget have on reducing the existing shortfalls and backlogs in the Department's "core" programs?

Answer: The higher funding levels in 1991 and 1992 will support the provision of quality health care to all veterans expected to apply for VA care on a system-wide basis. Policy and management decisions will be made to realign existing resources to reopen priority programs previously closed and place greater emphasis on utilizing appropriate care settings to improve quality and program efficiency.

Question: 10. Given the fact that the potential to conduct research is a major incentive in recruitment and retention of needed physicians as well as helping to improve the quality of care delivered to veterans, how can you reconcile a research budget which does not even keep pace with inflation and which reduces the award rate for medical research projects to 25 percent?

Answer: The FY 1992 funding level will support a strong research program at a slightly reduced level in comparison to FY 1991. The VA does not anticipate a negative impact on recruitment and retention of physicians.

Question: 11. It is my understanding that the Department's replacement equipment backlog is currently in excess of $750 million. To what extent is reducing this backlog a priority within the Department?

Answer: The equipment backlog counts any equipment that has reached its average life expectancy. Good preventive maintenance and only average use allow many units to be used beyond their average life expectancies. Greater than average utilization makes replacement necessary prior to the end of average life expectancy for other units. Next to initiatives which support direct patient care capabilities, replacement of equipment and upgrade of the physical plant are highest priority.

The Veterans Health Services and Research Administration recently validated the level of the equipment backlog. After thorough review at each VA medical facility, directors certified the accuracy of the corrected replacement equipment list. The result of this validation indicates that the backlog is expected to be approximately $864 million by the start of 1992. In the 1992 budget request a total of $155.2 million will be applied to replacement requirements. Because of the magnitude, several years of substantive funding will be required to reduce the backlog. Using this recently validated data, future budget requests will establish goals for a planned reduction of the backlog over a set number of fiscal years.

Question: 12. Could part of the replacement equipment backlog be offset through the expansion of sharing agreements? If so, to what extent?

Answer: Sharing agreements generally do not deal with equipment, as the Medical Center must have operational equipment in place in order to enter into a viable sharing arrangement. It might be possible that a Medical Center could fund small equipment purchases with funds earned through sharing agreements, but this prospect would be on an individual and limited basis.

VHS&RA does have a program for the joint purchase with private sector partners of high technology-high cost equipment. This program, however, pertains to jointly purchasing new equipment in instances where neither partner has sufficient patient need to justify purchasing the equipment on their own.

Question: 13. The committee has received testimony at recent hearings that service-connected veterans are being forced to wait for needed inpatient PTSD treatment. Is this still a problem and if so, to what extent will the additional funds requested for PTSD help alleviate this problem?

Answer: A survey conducted by the CMD's Special Committee on PTSD in January 1991, indicated that 17 SIPUs had a total of 333 veterans waiting to be screened for admission. The wait for program screening ranged from no wait to five months. The same survey revealed that a total of 993 veterans were waiting for admission to the programs and the waiting time for admission ranged from one week to

13 months. The results of this survey for each of the 17 SIPUs are attached.

The activation of new PTSD treatment programs and the staffing augmentation for several of the existing SIPUs as identified in the answer to Question 23a should contribute to a reduction in the waiting lists and waiting times for admission to the SIPUs.

Question: 14. Given that the VA has treated only a small fraction of the 479,000 Vietnam veterans believed to be suffering from PTSD and that the current capacity in the VA to treat these veterans is stretched precariously thin, how will the Department be able to care for more such veterans resulting from any hostilities in the Middle East?

Answer: As noted in the response to questions #4 and # 13, VA plans to expand its existing PTSD services. VA training programs for mental health clinicians addressing the management of acute traumatic stress disorders in Operation Desert Storm casualties have focused not only on those identified as primary psychiatric casualties, but also the mental health needs of casualties with primary physical injuries.

Question: 15. It appears that almost 90 percent of the billion dollar increase will go to payroll increases, inflation and other fixed costs. Given the fact that the Department did not factor into the proposed budget potential costs such as the $150 million projected for increased drug costs while relying on decreases to the base through what several witnesses have testified as arbitrary cuts and false savings ($20 million associated with medical cost recovery, $70 million reduction in hospital staffing, $28 million in activations, and $10 million in fee-basis "savings"), is it fair to assume that this budget request falls short of the current services level?

Answer: The rationale for including the various management initiatives in the Medical Care request are discussed below.

While no provision was made in the budget request for the effects of Section 4401 of the Budget Reconciliation Act of 1990, VA is actively pursuing strategies to ameliorate the anticipated effects of this legislation. Section 4401 provides for rebates to State Medicaid programs from pharmaceutical companies. The intended effect of the rebates is to assure that State Medicaid programs receive the "best price" in the market. Single Award contracts and VA depot are exempt from "best price" consideration.

VHS&RA is continuing to pursue Single Award contracts for pharmaceuticals. Approximately 225 items have been identified for such contracts. In addition, VHS&RA is exploring the possibility of increasing the number of items stocked in the VA depot system. VA is still interested in seeking exemption for all Federal Supply System (FSS) contracts. It is too soon to determine how these actions will offset the impact of the legislation.

With the establishment of the Medical Care Cost Recovery (MCCR) account, 500 FTE previously supported in the Medical Care appropriation are now included in the MCCR account. Since the Medical Care appropriation is no longer required to provide for personal services and support costs for this function, the appropriation can be reduced by $20.2 million.

The $70 million savings due to the shift of workload from inpatient to outpatient is discussed in our reply to Question 5.

A major portion ($289 million) of the decreases from the total activations request ($292 million) represents resources used on a non-recurring basis in 1991 for equipment and other one-time costs. These resources are available in the base to offset the cost of new nonrecurring project requirements in 1992. The remaining decrease of $31 million and 724 FTE reflects further review and refinement of planned activation requirements. The net effect of these changes is a decrease of $28.3 million to the level of dollars needed to support fiscal year 1992 activations.

The $10 million savings associated with the adoption of Medicare rates for Fee Basis is justified since Medicare rates are generally less than current VA rates paid to Fee Basis physicians.

In summary, these various management initiatives should improve the cost-effectiveness of VA medical programs and do not degrade our ability to maintain current services.

Question: 16. In answer to written questions submitted prior to our budget hearings, we learned that VA was "validating" its replacement equipment badly. When did this validation effort begin? When will it be completed? When did VA last complete an effort to revalidate its replacement equipment backlog? How will this latest effort improve upon the last one?

Answer: A major revalidation effort was recently completed to verify the accuracy of the replacement equipment backlog. Individual certification was obtained from every Medical Center Director following review of equipment items to insure that only those items requiring replacement were included in the backlog report. In addition, effective with the FY 1993 budget process, the "Square One" concept will be implemented which will provide a data base reflecting actual acquisition costs, actual acquisition years and established life expectancy standards. Replacement equipment lists have been reviewed on an annual basis, however, major revalidation by the Medical Center Director had not been required. The latest effort has resulted in the deletion of over $112 million from the backlog list.

Question: 17. What is the cost in dollars and FTE of establishing a Geriatric Evaluation Management (GEM) Program? From what source do you propose to "realign" resources to support the establishment of the GEM Program?

Answer: The cost per unit of establishing a new GEM Program is $107,000 and 1.5 FTE. The improvement in the utilization of appropriate care settings especially, the shift from hospital to nursing care and hospital to outpatient care is expected to realize sufficient resources to support the additional GEM units planned for FY 1992.

Question: 18. It's my understanding that the administrations proposed reform of the Beneficiary Travel Program would deny veterans living within 50 miles of a VA facility payment for the cost of emergency ambulance travel, special mode transportation, as well as for the cost of travel for frequent treatment such as dialysis care. It would, however, pay the full mileage rate to a veteran who drives 50 miles to a facility from his home. Please clarify the basis on which you characterize this proposal as a "reform" and advise us whether you believe it is fair.

Answer: Historically, when the word reform has been applied to a benefit change, it usually signifies an increase in the benefit. This travel proposal is part of a broader package that will increase some benefits at the expense of others. The current travel benefits will have to be decreased from a budget standpoint so that other eligibility benefits can be expanded. The primary purpose of this benefit is to allow veterans who are poor, unemployed, or retired, and in need of transportation to maintain access to a VA medical care facility. This provision will continue travel benefits for those veterans who are eligible for travel reimbursement and who have the least access to VA medical care (those living 50 miles from a VA facility).

Question 19: Is it realistic to project that VA's Chief Medical Director can run a hospital system of VA's size and complexity with a staff which grows smaller every year, and which, by 1996 would drop to half the staffing available to the Chief Medical Director in 1982?

Answer: As we work toward more centralized direction for medical programs and as we prepare to implement recommendations from the Commission on the Future Structure of VA Health Care, VHS&RA needs a strong headquarters more than ever. Cuts in Central Office over the last several years have worked against one of our most important goals to achieve more uniform implementation of national policy. There is clearly no room for cutbacks in MAMOE staffing.

For the past 10 years, VHS&RA's Central Office staff has done an excellent job in many areas, despite declining resources. For example, Pharmacy Service put in place a national IV solutions contract ($70 million savings) and a national "core" formulary (lowering costs up to 40%). They also succeeded in obtaining Clozaril at half the original cost, allowing more patients to have access to it.

At the same time, VHS&RA has not been able to fully meet goals in areas such as quality of care programs, equity of access, and a resource allocation process with appropriate incentives for productivity and efficiency. Additional resources may not have guaranteed achievement of these goals, but declining staff levels have slowed progress.

Question: 20. Please explain the reasons for the cancellation of the construction project for the Martinez, California VA Medical Center. What specific steps has the department taken since the project's cancellation regarding the budget plan "to support project development in the Northern California area?" Where are planners considering constructing a replacement hospital, assuming that were to be the department's plan, and what would be the timetable for such a project under the proposed major construction budget for FY 1992 and the out years?

Answer: There is a serious seismic risk at the site of VAMC Martinez. In developing the major construction project for that facility, efforts to design both an effective and safe hospital environment resulted in high cost estimates. The Department's concern about investing significant resources in a seismically risky site led to the cancellation of the project. The VA is actively evaluating options for VAMC Martinez including a replacement facility at another Northern California location. It is the VA's intent to request design funds in FY 1993 and construction funds as soon as possible thereafter.

Hon. Bob Stump to Department of Veterans Affairs

CONGRESSMAN STUMP

Question: 1. What are the proposed enhancements of the Financial Management System?

Answer: Enhancements of the Financial Management System (FMS) fall into three categories. First VA will continue to develop modifications and interfaces begun in April 1990. That work included 72 modifications and 16 interfaces to connect with existing or developing VA systems. The modifications cover a wide variety of functional changes, examples of which follow. In the budget execution area, processing of funds distribution must be streamlined because of VA's volumes from three step transactions down to one. VA also needs to allow field facilities flexibility in distributing funds to the lowest level of accountability. In the planning area, VA needs the ability to support FTEE reporting provided by existing systems. In the purchasing area, VA needs to track contract advances related to federal source purchases and construction contracts, as well as automatic accruals for service contracts. In the accounts payable area, VA needs to support electronic payment formats not currently provided for in the baseline system. Because of VA volumes, modifications are also needed in check grouping, vendor inquiry support, and processing intra-VA sales. Implementation of the VA construction accounting program has led to several modifications in the project cost accounting area to tie project budgets to the overall budget controls. VA also needs other general system changes to support simplified access to each field station's data. Customized reports, including a magnetic tape version of the IRS 1099, are also being pursued. An additional 12 modifications have been identified through the FMS pilot, begun in October 1990. In FY 1990, 18 of the modifications were fully funded and the remainder of the modifications plus all interfaces were only partially funded. FY 1991 funding has permitted further work on 10 modifications and 3 of the 16 interfaces. Successful completion of FMS is dependent on FY 1992 and FY 1993 funding to finish work underway.

A second category of enhancement to FMS is in the Loan Guaranty area. Although the original FMS design did not encompass Loan Guaranty processing, VA now views FMS as a viable solution to long standing material weaknesses in disbursement and fund control for the Loan Guaranty program. Additional interfaces must be built between Loan Guaranty systems and FMS to support this effort.

The third category of enhancement is in the benefit accounting area. VA has obtained consultant services to conduct a conceptual study and to examine alternative approaches to modernizing the financial management components of the benefit systems. One alternative being examined is the customization of off-the-shelf software. The enhancement provides for additional modifications and interface development to support the unique requirements of VA's benefit accounting programs.

Question: 2. What is the current processing time of a compensation claim, and how does it differ from last year? How do error rates and remands compare?

Answer: The current average processing time for an original compensation claim is 166 days whereas one year earlier it was 147 days.

Previous statistics on error rates were compiled from regional office reviews and were comprised of substantive, material and procedural errors for both rating and authorization actions. That method is being replaced by error rate statistics based only on Central Office review and comprised of payment or service errors, regardless of the source. These two methods of maintaining error rates are not directly comparable, and we are discontinuing the former in favor of the latter which we believe to be a more accurate assessment of our benefit delivery system.

Under the previous method based on regional office reviews our error rates were as follows:

	1989	1990
Rating		
Substantive Errors	1.92%	1.94%
Material Errors	2.28%	2.46%
Procedural Errors	3.80%	3.62%
Authorization		
Substantive Errors	2.98%	3.35%
Material Errors	3.72%	3.57%
Procedural Errors	6.65%	6.13%

Our new error rate statistics show payment errors of 2.6% and service errors of 6.2%.

The remand rate for FY 1989 was 22.1%. For FY 1990 it was 23.5%.

Question: 3. Could you give us a brief description of VBA's modernization of its Benefits Delivery Network and how it will assist in the delivery of quality and timely claims?

Answer: The VBA modernization project will provide VBA employees with the current technology and tools necessary to streamline work processes and improve services to veterans. The acquisitions to support the long term solution for modernization will be conducted in three stages.

Stage I, which began in 1990, will provide the RO computing platforms and local area networks needed to provide local ADP processing and to serve as the foundation for the modernized system. Contract award for the Stage I acquisition is anticipated for early 1992, with installation of hardware and software in the Regional Offices scheduled to be completed by mid-1993. The Stage II acquisition will provide specialized technologies including sophisticated local area network capabilities and specialized peripherals, such as image processors and smart cards. The Stage III acquisition, which will address centralized processing and applications, is projected to begin in 1993 and be completed in 1994.

Several features of the modernized system will have a positive effect on the quality and timeliness of claims processing. For example, unlike the current Benefits Delivery System, the modernized environment will feature on-line update of compensation and pension master records. This will provide better and more timely information in service to veterans and processing of claims. This on-line process will, for example, eliminate delays which now occur when award transactions fail to meet update criteria and must be recycled before any payment can be authorized.

The modernized system will also provide automated support for the front-end claims development process (now totally manual), thereby reducing the time it takes to get the claim into the hands of an adjudicator. VBA is presently conducting detailed workflow analyses in order to identify the specific opportunities to use electronic transmission of data to eliminate paper flows. Experience in one of the short-term initiatives has demonstrated reduced turnaround time on examination requests of more than ten days.

Modernization will also provide significant opportunities to improve interfaces with the Department of Treasury to result in more timely and accurate payments to veterans and their dependents and, thereby, reduce VA overpayments and the need for subsequent debt collection actions as well. Finally, the availability of current information simultaneously to various offices - through both on-line update of the master record and electronic imaging capability for claims folders - will permit concurrent review and action in various work processes now done sequentially. This will enable improved timeliness in claims processing.

Question: 4. Are you aware that funding problems at some of our medical centers this fiscal year have forced hospital management to divert money and staff from other accounts to meet operational needs? Can you assure us that such actions won't be necessary in FY '92?

Answer: We are not aware of a need for medical center managers to divert accounts such as equipment, non-recurring maintenance, community nursing home care, etc. into other accounts to meet operational needs. Regarding decentralized accounts such as contract hospitalization and fee medical and fee dental, medical center management have the flexibility to use any savings for staff and operating supplies. We do not anticipate any changes in FY 92.

Question: 5. It is my understanding that the department asked for $700 million in major construction funding for fiscal year 1992 yet received only $450 million. In light of the enormous difference in those figures, what impact will the proposed funding level have for fiscal year 1992 as well as for the succeeding fiscal years?

Answer: The Department believes that within the context of the limited resources available, the funding levels for major construction is adequate. Although the request to OMB was larger, most of the difference is the adjustment for Palo Alto, which we accommodated by including funding for the structural steel, thus not delaying the project.

Significant increases in the minor program as well as in the nonrecurring maintenance program reflect a shift toward seeking facility improvements where possible with less costly solutions.

Question: 6. The National Cemetery System is requesting budget authority of about $57 million and an FTEE ceiling of 1,200. That is an increase of $3.5 million (6.5%) in budget authority and a decrease of 37 FTEE. With this budget, will you be able to expand current cemeteries or open new ones?

Answer: The 1992 request is necessarily restrained by the current fiscal environment of budget deficits and resultant government-wide budget stringency. This restrained level of funding and FTEE, while having a negative impact on operations and maintenance of the cemeteries, will not delay any planned expansions of existing cemeteries; however, it will not be sufficient to open any new cemeteries. Though the construction of the new San

Joaquin Valley National Cemetery will be completed in November 1991, the 1992 funding level will necessitate a one year delay in its opening.

Question: 7. The Guaranty and Indemnity Fund has a funding fee that does not exceed 1.875%. Currently, a veteran can use his VA home loan entitlement more than once. The administration proposes to require a higher (2.5%) fee and a (10%) down payment for using it a second time. The risk for the second loan would be about the same as the first or even a little less. How can an increased funding fee be justified for comparable risk?

Answer: The proposal is based on the Administration's belief that the VA loan benefit should be on a pay-as-you-go basis for multiple users. The budget estimates the risk (expected default losses) for the first and second use to be about 2.5 percent of the original loan amount -- the subsidy cost to the Government. Under the budget proposal, the first time user, who currently pays a funding fee that does not exceed 1.875 percent, is not required to fully pay for his/her expected losses. The proposal does, however, require that multiple users -- except active duty servicepersons and VA interest rate reduction borrowers -- pay for the full risk to which they expose the Government.

Hon. Don Edwards to Department of Veterans Affairs

CONGRESSMAN EDWARDS

Question: 1. Mr. Secretary, there is a reduction of 37 FTEE in this budget for the National Cemetery System, at the same time that the new VA cemetery in Northern California is ready to go, but can't open because there is no staff for it. How and when is DVA going to get that cemetery opened?

Answer: Construction of the cemetery will be completed in November 1991. The 1992 request is necessarily restrained by the current financial environment of budget deficits and resultant government-wide budget stringency, and this has required a one year delay in the opening of the new cemetery. The necessary resources and FTEE to activate the cemetery will be requested in the 1993 budget.

Hon. George E. Sangmeister to Department of Veterans Affairs

CONGRESSMAN SANGMEISTER

Question: Mr. Secretary, as our veteran population continues to age, there is no doubt the future of the VA medical system will see an increased role for oupatient care. In fact, this budget emphasizes ambulatory care over hospitalization and cites a projected $70 million savings.

As you know, this new emphasis will add to the tremendous workload the system's outpatient, ambulatory clinics currently face. With this in mind, I would like the VA's assurances that it will expand its outpatient care availability as directed by Congress last year and continue to make this a priority in 1992. I would like to refer specifically to Joliet and Springfield-Decatur, Illinois -- projects I know you are aware of.

Answer: The initiatives, identified in report language accompanying the VA's FY 1991 Appropriation, are currently under review for funding along with many such proposals from all over the country. We have tried to maintain an objective, national policy using 75 miles as the minimum distance between a satellite clinic and the nearest VA medical center. In the case of Illinois, Decatur-Springfield meets this basic criteria for locating a clinic, while Joliet does not (60 miles from Hines VA medical center). We understand that a 60-mile trip may not be ideal, but more urgent needs exist in many places. A smaller scale outreach clinic may be possible at some time in the future but, again, funding is not currently available. However, while both proposals have merit, they would not be high enough priority to warrant reprogramming funding away from other areas for this purpose.

Hon. Harley O Staggers to Department of Veterans Affairs

CONGRESSMAN STAGGERS

Question: It is my understanding that the National Cemetery System has issued guidance to the military services to assist families and ease any problems associated with burials. These include the scheduling of burials on the day of choice of the family, including Saturdays, Sundays and holidays, and reducing the processing and delivery time of government headstones and markers. How do you plan to accomplish this when your budget request does not reflect the U.S. presence in the Persian Gulf and is already so inadequate that the condition of our national cemeteries is disgraceful? Your equipment's longevity has already been extended by 5 years and there's no money to water our cemeteries. What else is there to cut?

Answer: In support of our military personnel involved in Desert Storm and their families, NCS adopted the policies to which you refer. This entailed the redirection of some personnel and funding resources from other functions, especially grounds maintenance.

The NCS will continue to meet the challenge of providing the highest quality of service within available resources.

Question: Your budget document states that FY '91 current loan guaranty employment levels are 2165. Yet, as of yesterday, it is my understanding that you have approximately 2050 employees. Each and every year, through the appropriations process, Congress gives you specific funding for Loan Guaranty employees because supplemental servicing and quicker property disposition saves you millions of dollars. Yet, you come before us today and say you are going to cut an additional 114 employees. Your budget document does not consider the effects of interest rate reductions caused by the current recession on program activity nor the U.S. presence in the Persian Gulf which will create new Loan Guaranty eligibility. Shouldn't you be adding additional personnel to meet these work demands?

Answer: We are reviewing all areas of VBA to determine the need for a supplemental in 1991. The impact of Persian Gulf and interest rate reductions will be considered in that request.

Question: In regard to your proposal to exempt GNMA From No-Bids, doesn't it seem strange to you that the Department is being required to pay GNMA approximately $40 million so that agency can avoid losses on no-bids. GNMA currently receives 6 basis points (6/100ths of 1%) monthly in each veterans payments. Isn't that money supposed to go into GNMA trust funds to offset losses and to take care of contingencies such as no-bids?

Answer: It is the Administration's view that the GNMA program should not be required to pay for losses associated with defaulted VA for FHA loans. The 6 basis point fee charged by GNMA is primarily used to create a reserve fund to meet GNMA's obligation to provide timely payment of principal and interest to security holders, in the event that issuers (lenders) are unable to make their pass-through payment to GNMA. The GNMA reserve fund is not intended to cover losses on defaulted loans. The only time GNMA is exposed to such losses is in the case of a VA no-bid -- FHA pays for all losses on its loans. Moreover, the GNMA fee is the same for both VA and FHA loans. Since GNMA incurs losses only on VA loans, FHA borrowers cross-subsidize VA borrowers.

Under the proposal, VA does not make a payment directly to GNMA. When a VA loan defaults while in GNMA's portfolio, VA will always acquire the property and not exercise its no-bid option. The $40 million is an estimate of the cost of acquiring such property and does not reflect the fact that VA will recover a significant portion of that cost when the property is sold.

Question: Last year you proposed legislation to completely eliminate the Manufactured Home Loan Program. This year legislation is proposed to increase the funding fee on guaranteed manufactured homes from 1 percent to 2 percent and require veterans to make a 10 percent downpayment on these loans. Since veterans can obtain mortgage financing on manufactured homes with a 10 percent downpayment, what would be the advantage to the veteran to use the VA program? Doesn't your proposal have the net effect of terminating the Manufactured Home Loan Program?

Answer: While it is true that veterans can obtain conventional manufactured home loans with 10 percent downpayments, we believe that a 10 percent down VA manufactured home loan would still benefit veterans. Interest rates range from 1.5 % to 3% higher on conventional loans with 10% down than the interest rate on VA manufactured home loans. Also, the maximum term of a VA loan for a manufactured home is 20 to 23 years while conventional loans are often restricted to 12 or 15 years, and therefore carry higher monthly payments than the VA loans.

Question: You recommend requiring a 2.5% fee and a 10% downpayment for multiple use of Loan Guaranty benefits and recommend a 2% fee and a 10% downpayment for Manufactured Home Loan Program whether first time users or not. How do you come up with your proposals? Information previously furnished to us by your Department shows that default rates for second time users of the conventional housing program is 25% lower than first time users. Why are they being charged more than veterans using the Manufactured Home Loan Program who indeed do have a high default rate?

Answer: The proposal is based on the Administration's belief that the VA loan benefit should be on a pay-as-you-go basis for multiple users. The budget estimates the risk (expected default losses) for the first and second use to be about 2.5 percent of the original loan amount -- the subsidy cost to the Government. Under the budget proposal, the first time user, who currently pays a funding fee that does not exceed 1.875 percent, is not required to fully pay for his/her expected losses. The proposal does, however, require that multiple users -- except active duty servicepersons and VA interest rate reduction borrowers -- pay for the full risk to which they expose the Government.

As for Manufactured Home Loan Program (MHLP) borrowers, they do have a higher rate of foreclosure and their risk, i.e. subsidy cost to the Government, is estimated at 7.25 percent of the original loan amount. Because of the relatively low income of these borrowers (which is, in part, why they choose manufactured home loans) it is unrealistic to expect them to pay for their full risk. also, these borrowers do not receive the benefit of the new indemnity approach to liability if their loans are foreclosed. For these reasons, the proposed 2 percent funding fee and the 10 percent down payment is all that is requested of these borrowers to offset VA losses on their loans.

Question: It is my understanding that $128 million in administrative costs will be funded through certain benefits programs and that the general operating account will be reimbursed for these costs? Is this mostly through the loan guaranty accounts? Could you please provide a breakdown?

Answer: Almost $127 million of the total cost of credit reform will be funded by the three housing programs. The balance will be funded from the Vocational Rehabilitation Revolving Fund and the Education Loan Fund. The following is a distribution of the $128 million by benefit account:

Loan Guaranty Revolving Fund	$ 85,870
Guaranty and Indemnity Fund	39,689
Direct Loan Revolving Fund	1,368
Subtotal Housing Programs	$126,927
Vocational Rehabilitation Revolving Fund ..	936
Education Loan Program	307
Total Credit Reform	$128,170

Question: In terms of credit reform, it is my understanding that loan guaranty personnel will now be considered as part of the subsidy? I have been advised that loan guaranty currently has 2,050 employees; yet the subsidy coming out of loan guaranty funds is for 3,000. Don't you think this is a bit high?

Answer: We do not believe this estimate is too high. We understand that under the credit reform legislation, all administrative costs, both direct and indirect, which support our credit programs are to be charged to the appropriate credit account. Our estimate of 3,040 FTEE includes 2,051 FTEE in the Loan Guaranty program, 3 FTEE in the Compensation, Pension and Education program and 4 FTEE in the Vocational Rehabilitation and Counseling program. These FTEE total 2,058 and represent the direct labor which supports the Veterans Benefits Administration's credit programs. The balance of 982 FTEE represent indirect labor consisting of 197 FTEE in the Veterans Services program which handle veteran inquiries about our credit programs, 746 FTEE in the Support Services program which handle the administrative, fiscal and debt management activities which support our credit programs, and 39 FTEE in the Information Resources Management program who provide ADP support for our credit programs.

Question: In regard to credit reform it is my understanding that most of these figures were developed by the Office of Management and Budget. If you discover that these figures are somewhat inaccurate at the end of the year, how much flexibility will you have to restructure the numbers for next year's budget?

Answer: The budget estimates under credit reform were developed jointly with OMB and best reflect the program needs for each Fund. It is expected that the budget estimates will be revised since budgeting under credit reform is new and experience will need to be gained.

Question: Public Law 101-237 established the mortgage indemnity program which required the federal government to make a contribution in addition to the veteran paying a user fee. Who made the decision that the government contribution would be eliminated at the beginning of fiscal year 1992?

Answer: The Guaranty and Indemnity Fund Liquidating Account will receive the Government contribution in FY's 1992 and 1993, in recognition of the annual .375 percent contribution, for two years, on loans guaranteed during 1990, and .25 percent for three years, on loans guaranteed in 1991.

Section 507(a) of the Federal Credit Reform Act of 1990 was the basis for eliminating government contributions on loans guaranteed in 1992 and beyond. That section reads, in part, "... This title shall supersede, modify, or repeal any provision of law enacted prior to the date of enactment of this title to the extent such provision is inconsistent with this title".

For loans guaranteed in 1992 and beyond, credit reform requires that the budget authority for the loan guaranty program reflect subsidy cost to the Government, on a present value basis, for new guarantee loan commitments. Since the Governments' contribution, is itself a subsidy, it would be redundant to have two separate subsidy amounts for the Guaranty and Indemnity Fund Account. Eliminating the contribution does not effect the total budget authority. If the Government contribution was included, the subsidy budget authority, would be reduced by the same amount and the total budget authority would remain the same.

Question: During the February 20 hearing, you mentioned that you were working on a supplemental request in connection with Operation Desert Storm. Does this supplemental contain funding for the National Cemetery System? If not, why not?

Answer: No administration request has been made for Desert Storm related funding for the NCS. Costs for burials of Desert Storm fatalities have had a relatively minor affect on NCS operations. However, the Secretary, in his letter of March 7, 1991, to the House Budget Committee, seeks the authority to transfer some funds requested for Desert Storm from VBA to NCS. This authority will allow the Secretary to provide NCS with funding to improve its infrastructure, in preparation for public ceremonies on special days including Memorial Day and Veterans Day.

Question: It is my understanding that you did not receive the funding that you requested for the National Cemetery System. Did you appeal this decision to the Office of Management and Budget?

Answer: The OMB Passback did provide less funding for NCS than was originally requested. The passback funding was appealed and some of the original funding was restored. The final OMB allowance is only sufficient for an employment level of 1,200 FTEE and partial funding of inflation needs, with no programmatic increases in 1992.

Question: In regard to your legislative proposals affecting the Loan Guaranty Program, were any of these initiated by the Office of Management and Budget rather than the Department of Veterans Affairs? If so, did you appeal any of these initiatives?

Answer: All the legislative proposals affecting the Loan Guaranty Program were discussed with OMB. These proposals represent decisions of the Administration which DVA fully supports.

HON. CHRIS SMITH TO DEPARTMENT OF VETERANS AFFAIRS

CONGRESSMAN SMITH

Question: 1. For many years now, we have heard at various hearings that the VA lacked funds to sufficiently replace outdated medical equipment. In many instances, money has been siphoned from the equipment account to fund other programs, including direct care for veterans. In this year's proposal, the VA requests $143.7 million for new equipment even though it is estimated that $700-$800 million is needed to meet current needs. How and when will the need to replace medical equipment be addressed?

Answer: The equipment backlog counts any equipment that has reached its average life expectancy. Good preventive maintenance and only average use allow many units to be used beyond their average life expectancies. Greater than average utilization makes replacement necessary prior to the end of average life expectancy for other units. Next to initiatives which support direct patient care capabilities, replacement of equipment and upgrade of the physical plant are highest priority.

The Veterans Health Services and Research Administration has recently validated the level of the equipment backlog. After thorough review at each VA medical facility, directors certified the accuracy of the corrected replacement equipment list. The result of this validation indicated that the backlog is expected to be approximately $864 million by the start of 1992. In the 1992 budget request a total of $155.2 million will be applied to replacement requirements. Because of the magnitude, several years of substantive funding will be required to reduce the backlog to an appropriate level. Using this recently validated data, future budget requests will establish goals for a planned reduction of the backlog over a reasonable number of fiscal years.

Question: 2. Has the VA allocated Fiscal Year 1992 funds for the Activation/Operation of the Outpatient Clinic in Brick, NJ?

Answer: The outpatient clinic in Ocean County, New Jersey (Brick) will be fully activated in FY 91. Activation monies are not required for FY 92. Operating resources will continue to be provided in FY 92.

Hon. Timothy J. Penny to Department of Veterans Affairs

CONGRESSMAN PENNY

Question: 1. Mr. Secretary, we're surprised and disappointed the President didn't include an increase in the basic benefit rate paid under the Montgomery GI Bill in his FY 1992 budget. As you know, this benefit hasn't been increased since the GI Bill was enacted in 1984. We believe the members of our Armed Forces have more than earned an adequate, effective educational assistance benefit which will assist in their readjustment to civilian life.

1(a). What education benefit did a single veteran receive under the Vietnam Era GI Bill in 1974?

Answer: Under PL 93-508, effective 12-3-74, a single veteran received a full time rate of $270 monthly.

Question: 1(b). By what percentage have education costs increased since 1974?

Answer: Educational costs have increased approximately 125% since 1974.

Question: 1(c). By what percentage have education costs increased since 1984?

Answer: Education costs have increased approximately 42% since 1984.

Question: 1(d). By what amount would the basic benefit be increased under the MGIB-Active Duty and the MGIB-Selected Reserve in order to keep up with the increased costs in education since 1984?

Answer To cover increased education costs, the monthly rate for the MGIB-Active Duty would increase approximately $125 and MGIB-Selected Reserve $60.

Question: 1(e). How has the effectiveness of the MGIB as a readjustment benefit eroded since 1984?

Answer: Although growing dramatically, the program is in its early stages; therefore, it is difficult to evaluate its effectiveness as a readjustment benefit at this time. Trainee data is listed below:

Fiscal Year	Enrollees	Trainees
1988	599,720	5,729
1989	818,593	23,830
1990	1,005,751	101,781

Question: 1(f). Did you include an increase in the MGIB in the budget proposal you sent to OMB? If not, Why not?

Answer: Due to fiscal constraints an increase was not included in the budget sent to the Office Of Management and Budget.

Question: 1(g). What is the difference in income taxes paid by an individual with a high school diploma compared with those paid by a person with a college degree?

Answer: The annual income of year-round full time workers 25 years old and over by years of school and sex is:

	High School	Four Years College
Men	$25,394	$35,244
Women	$16,461	$23,406

This indicates there is a 14.4% increase in annual income for men and a 42.2% increase for women. The percent of this income that would be taxable would vary based on their adjusted gross income, but clearly indicates that annual income is influenced by education. (Source: "Digest of Education Statistics"; Twenty-fifth Edition, U.S. Department of Education, Office of Educational Research and Improvement NCES 89-643; Table 322, Page 367)

Question: 2. Last year's budget request included plans for four regional training seminars to ensure that those involved in the administration of the Montgomery GI Bill and other DVA education programs are fully informed about those programs. When I inquired about the seminars later in the year, however, I was told they had been canceled. I noticed that this year's budget again mentions training seminars.

2(a). Will these seminars, in fact, be held this year?

Answer: Yes. There are four regional training seminars scheduled for this year for the Educational Liaison Representatives.. The dates and location are:

April 15-19 Muskogee, Oklahoma
May 6-10 Atlanta, Georgia
June 17-21 St. Louis, Missouri
July 15-19 Buffalo, New York

As soon as the agenda is finalized we will provide you with a copy.

Question: 3. The Department's final response to the recommendations of the Commission to Assess Veteran's Education Policy should have been transmitted to the Committee last August. That report is now almost six months late.

3(a). Why have we not been provided with that final response?

Answer: Our final response is being reviewed by the Office Of Management and Budget. We have not been advised as to the exact date this will be released.

Question: 3(b). When will it be provided to the Congress?

Answer: The response will be sent to the Committee as soon as the review process is completed by OMB and subsequently reviewed by DVA, if necessary.

Question: 4. I continue to have serious concerns regarding the monthly certification procedures and the related delays in benefit delivery to veteran students. Last year I was told the Education Service was exploring the possibility of designing a method for veterans to certify their school attendance by telephone. What decisions have been made regarding this innovative idea?

Answer: We are currently working with a contractor to develop a prototype system. This system should be operational for the spring 1992 semester, at which time it will be utilized for a portion (approximately 10%) of the Chapter 30 trainees prior to consideration of expansion.

Question: 5. In Department budget documents you note that Veterans' Services public contacts (telephone calls, personal interviews, etc.) will decrease by 6.5% in fiscal year 1992. You also discuss the new responsibilities imposed on the Veterans' Services Program as a result of the Transition Assistance Program established under Public Law 101-510. Additionally, the budget requests only a straight-line FTEE level in FY 1992 for ongoing Veterans' Services activities.

5(a). A provision of Public Law 101-510 authorized $4 million for DVA for the implementation of the TAP program. Did the budget request you submitted to OMB include this funding? If not, why not?

Answer: The $4 million amount was an authority level in the National Defense Authorization Act of 1991. The resources were not appropriated. However, the VA's original FY 1992 budget proposal did include a request for funding to support Transition Assistance. The estimated resource requirements for VA were approximately $3.6 million, and were later modified to $2.2 million.

Transition Assistance funding was not approved for submission in the President's FY 1992 budget. Thus, because of our commitment to its accomplishment, we have identified our intent to accomplish Transition Assistance at the expense of the more traditional end products. Telephone actions, personal interviews and correspondence decline while information dissemination actions and away-from-office interviews increase.

Question: 5(b). What is the effect of the implementation of TAP, without additional FTEE, on the delivery of other services?

Answer: An increased demand for benefits information and assistance, to include our participation in the TAP, is expected to cause a decline in the overall timeliness of public contact activities. The greatest impact of this diversion will be on the Telephone Service (an estimated 500,000 additional unanswered calls) and Outreach Programs. The increase in the number of unanswered calls will be in addition to the projected FY 1992 abandoned call rate of 8.4 percent and blocked call rates ranging from 8 percent on local line groups to 27 percent on 800-service line groups.

Question: 5(c). What additional staffing would be necessary in order to fully support the TAP program?

Answer: An adequate Transition Assistance Program for FY 1992 will require a minimum of 60 FTEE to staff the 90 or so anticipated TAP sites in the continental U.S. Were these FTEE made available, interviews at hospitals and regional offices would be provided at an adequate level. Telephone service would be stable, with an acceptable abandoned call rate and a fluctuating blocked call rate of 8 percent on local line groups to 27 percent on 800-service line groups.

Question: 5(d). The Department standard that requires that service be given to 81 of every 100 who attempt to reach the DVA by telephone is barely acceptable, at best. Will you reach that standard in FY 1991? What level of telephone service do you expect to provide in FY 1992 with the requested staffing levels? How many additional FTEE would be needed to achieve the current telephone service standard?

Answer: Telephone service is currently being provided within the established acceptable quality level (AQL) for timeliness and quality. We anticipate that this will continue unless a considerable number of FTEE must be diverted for other programs, such as Transition Assistance.

We cannot accurately respond to the question of blocked calls and line needs to bring blockage to no greater than 10 percent at this time. We are in the process of converting our telephone service from AT&T to U.S. Sprint under the FTS 2000 contract. As of February 1991, only 25 stations have been converted. The conversion is not being accomplished on a geographic basis, but rather on a cost basis (those stations that will experience the greatest savings have been converted first). Conversion at the remaining 25 will be completed by October 1. (Eight stations will not be converted since AT&T costs are less than U.S. Sprint.) The conversion is eliminating foreign exchange lines in favor of all 800 service lines. The intent of the conversion was to save costs associated with the Telephone Service program. However, a side benefit has been to provide an increased level of service with fewer lines. This improvement is reflected in our FY 1992 projection of reduced blockage rates ranging from 8 percent on local line groups to 27 percent on 800-service line groups. Because of this ongoing project and the favorable preliminary results, VBA did not request additional FTEE or lines in the FY 1992 budget.

A traffic study covering the blockage rates and line needs for the 25 stations with U.S. Sprint lines has been requested and our evaluation should be completed by mid-March. We will better be able to respond to this question at that time.

Question: 5(e). Although many veterans need direct, face-to-face assistance, there are no veterans benefits counselors (VBCs) available for direct interviews in at least 24 of the 75 largest metropolitan areas in the nation. How many additional FTEE would be required to provide at least one VBC in each large metropolitan area and in each VA medical center?

Answer: To provide adequate service at decentralized service sites, 64 FTEE would be needed to add a resident office at each of the 64 major metropolitan areas where there currently is little or no face-to-face service. With the aforementioned FTEE and supporting funds for relocation, travel and equipment, personal service to veterans and their dependents and survivors at high density population centers would be acceptable.

Question: 5(f) What responsibilities will Veterans' Services personnel have in the event of significant casualties in the Persian Gulf War? What plans have been made to carry out these obligations if it becomes necessary? What will be the effect on current services if resources must be redirected to casualty assistance services, services to disabled servicemembers, and other combat-related services?

Answer: Veterans Services Divisions will be the primary benefits program liaison to the military departments and all servicemembers involved in Operation Desert Storm. Our staff will, in conjunction with the military, handle casualty assistance contacts with surviving family members of persons killed in combat. Veterans Benefits Counselors will be assigned to military medical facilities, VA medical centers and, in some cases, civilian hospitals to provide information and claims assistance services to persons wounded or injured as a result of Desert Storm operations. Veterans Services will also serve as the primary control point for the tracking of disability and other benefits claims through the VA system and will provide all necessary followup services to servicemembers, new veterans and families.

At the same time, Transition Assistance services will be provided to servicemembers preparing for separation from active duty.

Since the casualty rate due to Operation Desert Storm was much lower than that which was planned, there will be little or no impact on existing operations.

Question: 6. I consider the provision of vocational rehabilitation and counseling services to service-disabled veterans a primary Department mission. In recent years, we have been deeply concerned by the unacceptable timeliness and resulting diminished quality of those services as a consequence of inadequate VR&C staffing.

6(a). How many additional FTEE would be required to reduce the vocational rehabilitation specialist (VRS) caseload to 150 cases per VRS? 125 cases per VRS? What would be the effect on timeliness (average number of days in applicant status and employment status) if caseloads were reduced to each of these levels?

Answer: An additional 48 FTEE would be required to lower the VRS average to 150. The effect on timeliness (average number of days in applicant status and employment status) if caseloads were reduced to this level are as follows:

	1992
Applicant Status	78
Employment Status	225

An additional 95 FTEE would be required to lower the VRS average to 125. The effect on timeliness (average number of days in applicant status and employment status) if caseloads were reduced to this level are follows:

	1992
Applicant Status	70
Employment Status	200

While an expected result of the additional staff would be improvement in these key timeliness indicators, an important additional result would be an increase in the number of veterans who achieve rehabilitation.

Question: 6(b). We anticipated a reduced VRS caseload as a result of additional staff provided last year. Why didn't the caseload go down?

Answer: We are currently in the process of recruiting and hiring the additional VRS staff. Once those VRS's are in place, the caseload per FTEE will be reduced. The reduction, however, may not be immediate, as it takes time to properly bring these people to journeyman level.

Question: 6(c). As important as the number of staff is the quality of that staff. During hearings last year we were told that VR&C was in the process of rewriting the job description for the VRS position, a step we strongly supported. What progress has been made regarding this issue?

Answer: Chapter 31 of Title 38, U.S.C. gives the Secretary the authority to set qualifications standards for the employees of the Vocational Rehabilitation and Counseling program. We expect to implement improved qualification standards for our VR&C staff in FY 1993. We believe that these new standards will assure that we employ the best available people to accomplish the goals of the program.

Question: 6(d). VR&C staff play an important role in the provision of services under the transition assistance program for disabled military personnel -- D-TAP. Did you request additional staff for this program? What will be the impact on the provision of traditional VR&C services if existing staff must be diverted to D-TAP? How many additional FTEE are necessary to effectively implement D-TAP without a negative effect on other VR&C services?

Answer: We requested an additional 14 FTEE to implement D-TAP. If current staffing is directed toward D-TAP, without additional staff, testing and evaluation services and placement services may have to be contracted out. In addition, each office will have to work more closely with the state vocational rehabilitation system to augment our own staff. With the expansion of D-TAP, approximately 10 FTEE and $477,000 would be required to fully support the D-TAP program in 1991. This would provide face-to-face contact between the disabled service member and the Vocational Rehabilitation Service staff at 45 sites. In 1992, a total of 20 FTEE would be required to expand D-TAP services to a total of 90 sites. Our goal is to provide the face-to-face contact with the service member as resources permit. However, at a minimum, we will place a separation package in the hand of every veteran awaiting discharge from the Armed Forces.

Question: 6(e). When reviewing the workload analysis in the DVA budget documents, I noticed some numbers that puzzled me.

1. First, the number for evaluation and planning in 1990 was 36,541. Last year, however, the estimate was for 31,400. That was a significant underestimate. How accurate are the estimates for 1991 and 1992? Might they also be significantly underestimated?

Answer: The number of veterans in applicant and planning continually increased during FY 1990, in excess of the original estimates. This appears to have been due, in part to the softening of the economy and the consequent increase in the unemployment rate. The termination of the Chapter 34 program in January 1990 and effects of early separation programs for some first-term military personnel appear to have been contributing factors in the rise in the number of veterans in evaluation and planning in FY 1990 as a large number of veterans previously training under Chapter 34 lost those benefits before their programs were completed and applied for Chapter 31 benefits. It is anticipated that the estimates for 1991 and 1992 will also be affected by the condition of the economy and the rate of unemployment. The estimates have, however, been increased based on the FY 1990 experiences.

2. The 1990 actual for vocational/educational counseling was 2,786. Last year's budget estimated 9,220 counseling cases for 1990. What accounts for this dramatic shortfall? Are eligible persons being made aware of the availability of counseling?

Answer: The number of veterans requesting counseling under Chapter 34 diminished with the demise of that program in January 1990. It was anticipated that the number of veterans requesting counseling under Chapter 30 would proportionately increase. That expected increase has not materialized, perhaps because the question on the application which asks the veteran if he/she desires counseling services was removed. However, through the Transition Assistance Program and the VA's "800" numbers, the veteran may be made aware of counseling availability.

Question: 6(f). I notice that funding has been provided for two annual issues of the Vocational Rehabilitation and Counseling Professional Review. I would appreciate being provided copies of each of those publications. Since this document is to be published only once a year, what other means are used to communicate innovative ideas, developments, problems, etc., among the VR&C professionals across the country?

Answer: We will be happy to share copies of the Review with you. In addition to the Review, the Vocational Rehabilitation Service conducts monthly conference calls with the regional office staffs, disseminates written materials of interest, and holds annual workshops for selected staff. In FY 1990, VR&C made funds available to 7 regional offices which developed and conducted staff development workshops for themselves and staffs of neighboring regional offices. In addition, the Vocational Rehabilitation Service produced the first VBA satellite teleconference on timely rehabilitation topics. In December 1990, the Vocational Rehabilitation Service formed a VR&C Field Advisory Committee which represents VR&C staff in each of the 4 VBA areas. This group has met twice and provides us with useful guidance on VR&C policy and procedure. We plan, in FY 1991, to continue using every vehicle available to us to keep our staff up-to-date.

Question: 6(g). In the event there are significant casualties as a result of Desert Storm, what plans have been made to provide vocational rehabilitation services to those who need them? What will be the effect on the provision of ongoing VR&C services?

Answer: VR&C will aggressively engage in activities, at the earliest possible time, designed to facilitate the provision of needed rehabilitation services to Desert Storm participants. Seriously disabled veterans will be given highest priority. Many current services, such as motivation visits for non-Desert Storm participants will be curtailed. Initial contacts and VR intervention will be made quickly at local military and VA hospitals. Initial vocational assessment, i.e. paper and pencil testing, when appropriate can be started at this time. Contracting out services may be a viable option if the number of casualties is high. Field staff members are being trained accordingly to handle the types of injuries that may be more prevalent from this war than from previous wars.

We will use every resource to assure that no veteran participating in a vocational rehabilitation program is significantly impacted because of VR&C workload.

Since the casualty rate due to Operation Desert Storm was much lower than that which was planned, there will be little or no impact on existing operations.

Hon. Douglas Applegate to Department of Veterans Affairs

CONGRESSMAN APPLEGATE

Question: Mr. Secretary, I see that you propose 30 additional FTEE for the compensation and pension programs above the current estimate of 4,226. What is the actual level as of today? What level of FTEE do you expect to reach in 1991?

Answer: At present the actual level of FTEE is 3891. Our authorized ceiling for 1991 was increased to 4226. We anticipate that we will have 4226 personnel on board by the end of the fiscal year.

Question: Do you expect to make any progress in your timeliness and quality statistics? If not, why not?

Answer: The FY 92 budget does not promise significant improvements in our declining timeliness. The 92 staffing levels should be sufficient to halt the trend of deterioration in timeliness. It is difficult to estimate at this time how the large amounts of new work from the Budget Reconciliation Act will interact with the learning curve of the high number of trainee adjudicators, presently 35%, and forecasted to go to approximately 40%. VBA has no source from which to obtain trained adjudicators and rating specialists. FTEE which we have added are still in training or remain to be trained. It takes from one to two years of training before a new adjudicator or rating specialist becomes fully productive. We anticipate that by the end of FY 1992 our work force, while still having a high percentage of trainees, will be sufficiently trained, on the whole, to approach the production levels of journeymen adjudicators.

Quality levels will be affected by the same factors as timeliness. Experience indicates that the quality of adjudicative actions will be affected by the high level of trainees. We expect that improvement in quality will be evident in early FY 1993.

Question: Do you have any plan to consolidate any adjudication functions? If not, would you please tell us why?

Answer: We do not currently have any plans for consolidation of adjudication functions. We will, however, examine the possibility of regionalizing those services that truly do not require face-to-face contact with beneficiaries.

Mr. Secretary, I also have a few questions regarding the Board of Veterans' Appeals. An inadequate level of staffing has been requested, and I'd like to know why. It seems to me that during fiscal year 1990 you started making good progress in reducing the Board's turn-around time in its final decisions.

Question: Why are you recommending a cut of 27 FTEE?

Answer: The Board of Veterans' Appeals (BVA) was not singled out as a target for staff or funding reductions. BVA is one of several VA organizations funded from the General Operating Expenses (GOE) appropriation. Because of the limitations associated with the terms of the reconciliation agreement, overall funding for all GOE offices is constrained in 1992. The 27 FTEE reduction in BVA staffing reflects BVA's proportionate share of the total 1992 reduction in GOE funding relative to the 1991 current services level.

Question: What is your current projection of the BVA workload for fiscal year 1991 and 1992?

Answer: BVA expects to receive 45,000 appeals annually in both FY 1991 and FY 1992.

Question: Did you ask for a higher number than 400 FTEE? If OMB cut your request, did you appeal that decision?

Answer: Our original request to OMB did include additional FTEE and funds for BVA, and we did appeal a portion of the amount cut from our request in OMB's initial passback.

Hon. Lane Evans to Department of Veterans Affairs

CONGRESSMAN EVANS

Question: 1. In Iowa, non-service-connected Category A veterans are denied outpatient medication when a condition is judged to be chronic and stable. In Texas, a veteran with identical eligibility and the same medical condition will continue receiving outpatient medication. What action will you take to insure that veterans with identical eligibility and the same condition receive identical care throughout the system? What does this budget do to ensure veterans who have the same eligibility receive the same care regardless of their location? How does the proposed budget reduce or eliminate inequities in the provision of health care to veterans?

Answer: In FY 1991, the last of the three years of discrete facility-specific adjustments for equity of access was made. That completed the process initiated by the Chief Medical Director in FY 1989 to promote the uniform geographic availability of medical care resources to veterans.

Beyond FY 1991, VHS&RA will integrate the principle of equity of access into the resource planning and management (RPM) process being prepared to replace the previous resource allocation system. RPM will be used to identify gaps, overlaps, or imbalances in programs and services. The new process includes the development of a National VA Health Care Plan which will be the basis for adjustments, additions, or deletions to the missions and programs of VA medical centers.

This VHS&RA program initiative is being designed to assure that comparable levels of care are given to veterans in all areas of the country.

Question: 2. How does the proposed budget address the increasing number of women veterans?

Answer: There is no line item in the FY 1992 budget for women veterans. Even though women veterans are considered a minority population within the VA system, the VA anticipates a slow but steady growth in the women veteran population and a concurrent growth in VA services to women veterans.

Question: 3. How many homeless veterans are currently served by the Department's special programs for homeless veterans? What percent of the homeless veteran population is currently served by these programs?

How many homeless veterans will be served by the proposed budget?

Answer: The Homeless Chronically Mentally Ill (HCMI) Veterans Program will provide outreach and initial clinical assessments for approximately 10,000 homeless veterans in 1991. Approximately 3,300 will be placed in over 200 community-based residential treatment facilities for ongoing treatment and rehabilitation, paid for through VA contracts.

The Domiciliary Care for Homeless Veterans (DCHV) Program is expected to serve in excess of 17,000 veterans in FY 1991. It is estimated that 3,500 patients will be admitted and that 427,815 days of care will be provided.

In providing services to 10,000 homeless chronically mentally ill veterans, VA's HCMI program will reach about 5.5% of the estimated 180,000 homeless veterans in FY

1991.

The DCHV Programs expects to serve approximately 8.3% of an estimated 180,000 homeless veterans in FY 1991.

The proposed 1992 budget for the HCMI Program will primarily allow the program to maintain the current level of services to homeless veterans by offsetting increases in per diem rates charged by the contract community-based residential treatment facilities. Some HCMI Programs may be provided additional staff to assist with outreach and case management activities. In addition, some HCMI Programs may be used to place additional veterans in community-based residential care or the funds may be used to allow the same number of veterans to remain in contract facilities in order to benefit from slightly longer episodes of care.
The proposed 1992 budget will allow the DCHV Program to serve approximately 19,500 veterans, admitting 3,900 and providing 474,135 days of care.

Question: 4. According to testimony presented before the Subcommittee on Oversight and Investigations, for every Vietnam veteran being treated by the VA for PTSD there may be five or six other significant PTSD symptomology who are not receiving VA treatment. Recognizing a vast majority of these veterans may not be eligible at a high priority for the PTSD services which do exist, how does the VA intend to increase the number of Vietnam veterans being treated for PTSD? How does the Administration's budget respond to this situation?

Answer: VA attaches a high priority to providing treatment to all veterans suffering from PTSD with a particular emphasis on caring for those who have PTSD as a result of their war zone experiences.

VA's budget reflects a commitment to maintain the current level of treatment services that exist or are being activated in FY 1991. This not only includes the network of specialized PTSD programs (52 PTSD Clinical Teams, 25 Specialized Inpatient PTSD Programs and 17 dual diagnosis programs for veterans with both PTSD and Substance Abuse Disorders); it also includes the ongoing capability to provide PTSD treatment in general psychiatry inpatient and outpatient programs across the VA medical care system.

Readjustment Counseling Service vet centers see approximately 115,000 veterans and provide over 600,000 visits to veterans and family members per year. Eligibility at vet centers is an entitlement for all Vietnam era enlistments and there are no waiting lists for services. Current plans are to maintain this level of services for Vietnam era veterans into the foreseeable future.

Question: 5. How much funding is provided in the proposed budget for VA Total Quality Management activities?

Answer: The budget does not contain a specific request for Total Quality Management (TQM) activities. Funds previously used for A-76 and efficiency review activities will be redirected to meet TQM funding requirements.

Question: 6. How many projects are included in a typical 5-year plan? What percent of the projects included in a 5-year plan are funded during the initial five year period of a 5-year plan?

Answer: Within an individual facility's 5-year plan, the number of projects considered for planning in any one year can vary widely based on facility size, age, condition and physical plant. The projects from these 5-year plans are consolidated into the Five Year Medical Facility Development Plan (MFDP), and reflect strategies developed from a departmental perspective that identify VA systemwide priorities.

The current MFDP for 1990-94 includes 73 major medical construction projects. The five year period 1988-92 was included in the MFDP published in June 1987 and identified 73 projects. There were 36 of these projects that have been fully funded or included in the President's FY 92 Budget Request.

Question: 7. How many community nursing home beds will be available for VA sponsored patients in 2000, 2010, and 2020 based on your projections? How many veterans will be in need of nursing home care in each of those years based on your projections?

Answer: Currently, VA planning projections for VA-sponsored veterans in need of nursing home care is based on a 16 percent market share and a 30-40-30 percent program mix distribution (VA-owned, community, and State respectively). The projection assumptions are based on historical utilization trends developed in a 1985 National Nursing Home Survey and maximum utilization of available and suitable community and State nursing home beds. In addition, the planning projection for program mix assumes that the community share will be accommodated by a growth in available community nursing home beds that is equal to the growth in veterans in need of nursing home care. The following planning projections are provided:

Year	Total Vets in Need	VA Mkt Share (16%)	Community Share
2000	294,968	47,195	18,878
2010	387,237	61,958	24,783
2020	350,512	56,082	22,433

Question: 8. According to GAO, VA's long-range plans relating to medical facilities call for spending about $9.8 billion to repair or replace aging facilities. Please describe and provide a schedule for VA's long range plans to repair or replace aging facilities.

Answer: Within available resources, the VA plans to make necessary repairs or to replace aging facilities through an integrated program using construction and maintenance projects as appropriate. The "future projections" for construction programs indicate annual authorizations in the range of $600 million per year to support all construction programs for the next several years.

Please also recognize that the request for both minor and minor miscellaneous projects have been increased by $54 million and $10 million respectively in FY 1992 and similarly in the out years. This increase reflects VA's commitment to continue to maintain the quality of facilities providing veterans care despite the budgetary constraints on construction of new facilities.

The planning process enables VA to review construction projects and develop priorities to ensure the most urgent needs are met.

Question: 9. A previously proposed budget identified improving the management of VA programs and the quality of VA services as two top priorities of Secretary Derwinski. What specific improvements have been made in the management of VA programs and the quality of VA services during the last two years?

Answer: Improvements to the management and quality of VA programs and services are currently being addressed through the Secretary's Strategic Management Process. This new process includes two overriding goals for the future of the Department of Veterans Affairs: 1) to provide the most compassionate, high quality services to veterans and their families, 2) to be the most responsive and best managed service delivery organization in the federal government. Although these goals are aimed at strategic planning for fiscal years 1992 through 1996, they are already being realized by activities underway in FY 1991. The activities which support the two goals of the Strategic Management Process are monitored on a quarterly basis and can be illustrated by the following initiatives of the Veterans Health Services and Research Administration.

Goal One: Provide the Most Compassionate, High Quality Services

Provide For the Needs of an Aging Veteran Population.
VHS&RA plans to add a total of 557 VA-owned nursing home beds by the end of FY 1991. After the first quarter, VHS&RA had increased the number of VA-owned nursing home beds by 33.

Provide a Full Continuum of Health Care.
By the end of the fiscal year, VHS&RA plans to increase the number of general outpatient visits conducted by a total of 478,000. In the first quarter of FY 1991, VHS&RA increased the number of general outpatient visits by 71,000.

Goal Two: Be the Most Responsive and Best Managed Service Delivery Organization

Improve Quality, Management, and Efficiency of VA Health Care.
In order to reduce nurse shift rotation, VHS&RA plans to increase nurse staffing levels by 798 FTEE in FY 1991. As of February 7, VHS&RA had increased the nurse staffing levels by 453 FTEE.

Maintain Facilities and Infrastructure.
VHS&RA plans to reduce the clinical replacement equipment backlog by $113.210 million during FY 1991. In the first quarter, VHS&RA reduced the clinical replacement equipment backlog by $4.9 million.

Question: 9. What goals have been established for improving the delivery of services by the Veterans Benefits Administration and particularly for improving the timeliness and accuracy of claims adjudication?

Answer: Our goal is to provide the best benefit delivery system in the government. VBA has two major initiatives in support of that goal. The first is modernization of our equipment. Stage I is fully funded in the FY 1992 budget request and includes such items as the automated exchange of medical information between VA medical centers and regional offices and improved letter writing capabilities for providing better notice to claimants about our decisions.

The second initiative involves improved training for our adjudicators. The Adjudication Academy, which was funded by Congress two years ago, is providing excellent training and can only serve to improve timeliness and quality in the future.

Question: 10. What percent of original compensation claims are currently processed within 90 days? How many additional full-time employees are needed in order for 35% of original compensation claims to be processed within 90 days? How many additional full-time employees are needed in order for 50% of original compensation claims to be processed with 90 days?

Answer: Currently, 25.2% of original compensation claims are processed in 90 days or less, however there are no simple mathematical answers to the remaining questions. We do not dedicate our employees to processing only one type of claim, nor do we train them in such a narrow discipline. Our adjudicators must be able to handle a wide variety of claims in a timely and accurate manner, and the simple addition of untrained full-time employees would not, by itself, improve the timeliness of original compensation claims.

In addition, recent studies show that there are a number of factors external to VBA which affect processing timeliness. For example it takes an average of almost 73 days to secure service medical records and almost 60 days to obtain medical examination reports. Therefore, adding staff alone will not produce significantly better timeliness.

Question: 11. The President's proposed budget requests $42 million to support VBA modernization initiatives, but this support would not be available until fiscal year 1993, according to the budget. Why have funds not been requested for fiscal year 1992 to support VBA modernization initiatives?

Answer: The President's 1992 request does include $42 million to award and obligate the contract(s) for first stage of VBA's long-term modernization solution in FY 1992. However, in order to support the outlay limits included in the current deficit reduction plan, the 1992 request includes language which would make the funds available only in the month of September 1992 so that the outlays for these obligations would not occur until FY 1993.

In addition to the $42 million, the 1992 budget request for modernization includes $25 million for short-term projects, contracts which support the long-term solution and on-going technology enhancements such as the Model Station. The 1992 request estimates that the outlays for these $25 million will occur in FY 1992.

Question: 12. In January, VA reported details of a common billing plan and reimbursement rates for VA/DOD contingency had been worked out with three military branches, procedures were in place to monitor the financial aspects of contingency hospital operations, and DOD had assured VA of timely reimbursement. In addition to providing specifics on DOD reimbursement rates and timeliness agreements and tracking and billing systems, describe current cost and reimbursement agreements for care given to veterans transferred to community facilities by VA due to Operation Desert Storm.

Answer: The VA/DoD Contingency plan was not activated, however, the following describes how it would have worked. DOD agreed that the interagency billing rates for fiscal year 1991 would be used as the reimbursement rate for national billings prepared for treatment provided to Operation Desert Storm patients. Reimbursements from other federal agencies are considered automatic reimbursements. The result is that VHS&RA would have had an increase of obligation authority as soon as the bill entered into the system. The increase in obligation authority would be disbursed to the appropriate medical centers. Payment for care provided to veterans transferred to community facilities by VA due to Operation Desert Storm would be made from the medical care appropriation.

Question: 13. According to the most recent (12/31/90) VA Federal Managers Financial Integrity Act report, "VHS&RA has indicated that there are no statistics on drug inventory loss. Neither, Supply, Pharmacy nor Nursing Services has an inventory of all drugs." In detail, explain why VHS&RA has no statistics on drug inventory loss and why neither Supply, Pharmacy nor Nursing Services has an inventory of all drugs? Does any other service in VA have or maintain an inventory of all drugs or drug inventory loss? If "no", please explain why no such inventory is maintained.? What is the estimated cost of the failure to maintain an inventory and statistics on drug loss?

Answer: The Office of Acquisition and Materiel Management (OA&MM) procures, stocks and distributes pharmaceutical items through its central distribution system for use at individual VAMCs. Drugs procured and distributed through OA&MM's supply system are accounted for in a perpetual inventory systems of accounts. Drugs distributed in this manner are tracked from the moment they are received until they are issued to individual pharmacies. Within the tracking system, losses of drugs for whatever reason have to be explained and accounted for.

VHS&RA has not developed DHCP software that will result in Pharmacy Service being able to maintain accurate inventory data on all pharmaceuticals and compile statistics on drug inventory loss. Enhancements are planned to current software packages that will provide the mechanism to obtain statistics on inventory loss. No other service maintains an inventory of all drugs nor a record of drug inventory losses, with the exception of records of reported thefts which are maintained by Security Service. The cost of the failure to maintain an inventory and statistics on drug loss cannot be estimated.

It should be noted that the automated Unit Dose Dispensing system, which will be operational at 83% of VA facilities by 1992, simplifies records management while improving accountability for all drugs utilized. By greatly reducing local drug inventories at the hospital level, Unit Dose Dispensing significantly reduces drug inventory loss from theft.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

JAN 28 1991

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are the responses to questions concerning VA's role as a contingency backup to the Department of Defense's Operation Desert Shield/Storm. The responses are to questions you submitted in your letter, dated January 11, 1991.

Responses to the remaining budget questions will be forwarded to your staff by their due date of February 11, 1991.

Please let me know if we can be of further assistance.

Sincerely yours,

Edward J. Derwinski

Edward J. Derwinski

Enclosures

EJD/map

CONGRESSMAN MONTGOMERY

Question: 1 The Department of Defense's implementation of Operation Desert Shield has clearly had an impact on the operation of VA medical facilities. VA has kept this Committee aware, for example, of the numbers of Veterans Health Services and Research Administration (VHS&RA) personnel who have been mobilized in connection with Reserve obligations. Have VA medical centers partially or fully replaced these personnel through the exercise of authority to contract for scarce medical specialist services (or through any other mechanisms)? If so, what percentage of vacancies attributable to Desert Shield have been filled (in whole or in part) through such contracts (or through "purchase orders")?

Answer: Medical centers have begun to replace some mobilized personnel through the use of contracts. They have also hired some new employees to replace those who are gone and have made extensive use of overtime. Data reported to VHS&RA indicates that from 6-12% of the employees mobilized have been replaced with contract or other fee services to date. As time passes and the mobilized employees do not return to their home facilities, we would anticipate that this percentage might increase unless the availability of replacement personnel makes it feasible to hire behind the mobilized personnel.

Question: 2 What additional cost (or if it is not possible to calculate such costs precisely, what approximate cost) is VA incurring in the aggregate per month to contract or otherwise obtain services to fill personnel vacancies attributable to operation Desert Shield? Have anticipated costs of contracting for such replacement services led VA medical facilities to forego or abandon filling such vacancies? if so, in what specialties and in what numbers in the aggregate?

Answer: We have not yet observed any significant number of facilities that have foregone filling vacancies created by mobilized personnel due to costs of contracting for replacement services. Through the first quarter of FY 1991, we estimate that it has cost us approximately $800,000 to contract for replacement services in our facilities. This cost is fully offset by the salary dollars we are not spending on the mobilized employees. As reserve and national guard call-ups continue and given the difficulty we already experience in recruiting many types of providers, we would anticipate that our contracting costs could increase substantially. At the same time, the continued mobilization would generate greater savings as more and more employees enter the leave without pay status from the Department. We will continue to carefully monitor the net effect of the mobilizations to ensure that the level and quality of care in VA medical care system does not suffer.

Question: 3. Have DOD procurements of pharmaceutical and equipment requirements associated with Operation Desert Shield resulted in shortages, or unavailability, of supplies needed by VA medical facilities? If so, what specific items, if any have been altogether unavailable?

Answer: There is no complete outage of any pharmaceutical. There is a nationwide shortage of immune globulin for intramuscular injection. Nationwide supply of the product was exhausted with the need to immunize all DoD service personnel sent to Saudi Arabia for hepatitis. The manufacturer is holding a small supply for domestic use which is released by the manufacturer to the hospital on a case-by-case basis. We do not anticipate that this will present a patient care problem at this time. Additionally, there is a nationwide shortage of intravenous serum albumin for use in cases of massive blood loss. The shortage could have a significant impact on patient care if it is sustained for any extended period of time.

Question: 4. What has been, or what is likely to be, the impact of the continued unavailability of such supplies on the operation of VA medical facilities? To the extent that VA has experienced extraordinary delays in obtaining needed supplies attributable to the impact of DOD's Desert Shield, what has been or what is likely to be the impact of such delays on VA operations?

Answer: To date the delays and unavailability have not presented operational difficulties to VA medical centers. VA is in constant communication with vendors and will continue to monitor it's logistical ability during this event.

Question: 5. Has VA entered into any agreement(s) with DOD or the service departments to furnish VA with supplies VA will need to provide care to DOD personnel? If so, please furnish a copy of such agreement(s). If not, why not?

Answer: VA is currently working with DOD to complete interagency agreements for acquisition and supply support for pharmaceuticals, medical supplies, equipment, and subsistence during a national emergency. These agreements would permit VA to be recognized as a priority customer for these commodities consistent with DOD policies for prioritizing and allocating military readiness needs. Copies of the draft agreements are attached.

Question: 6. Public Law 97-174 provides (as codified at 38 USC sec. 5011(c)) that DOD shall reimburse VA for care or services which VA provides members of the armed forces during war or a national emergency "at such rates as may be agreed upon" by the respective Department heads "based on the cost of the care or services provided." Other than the very general terms of a VA-DOD memorandum of understanding on contingecy planning executed in December 1982, have VA and DOD formally entered into an understanding to the effect that DOD will reimburse VA for such care and have the Departments formally adopted the methodology by which such payment rates will be set? If so, please furnish copies of such agreements. If not, what steps will VA be taking to clarify these matters?

Answer: In 1986, VA and DoD formally agreed that reimbursement to VA facilities will be at the interagency rates established according to OMB Circular A-11, Section 13.5(a) in effect at the time that care is provided. Because the interagency rates do not include the cost of transportation or prosthetics, the actual cost of these services will be billed in addition to the interagency rates (Memorandum of Understanding dated 10 June 1986, attached).

92B

Mr. Roger C. Roy
Assistant Director, Policy and Plans (DLA-LR)
Defense Logistics Agency
Headquarters - Cameron Station
Alexandria, VA 22304-6100

Dear Mr. Roy:

Reference is made to your letter of April 23, 1990, requesting us to review and comment on your revised agreements to recognize the Department of Veterans Affairs (VA) as a priority customer within the Department of Defense (DoD) supply system for medical and subsistence items during periods of national emergency. We have completed our review and recommend that the enclosed final versions be signed.

When signed, the agreements should be returned to Associate Deputy Assistant Secretary for Resources (91A).

Should you require any additional information or assistance in this matter, please contact Mr. Dennis Easton at (202) 233-4345. Your assistance and cooperation in completing these interagency agreements are appreciated.

Sincerely,

DAVID S. DERR

David S. Derr
Associate Deputy Assistant
Secretary for Materiel

Enclosures - 2

cc: 90/RF
90A/RF
90D/RF
90M/RF
90R/RF
91A/JEFFERIES
92B/RF
92B/EASTON

DEASTON:de 6/20/90 92B 91A 90R 90A 90D 90M
(Doc #2095H)

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IGA V101(91)M-90025

INTERAGENCY AGREEMENT
BETWEEN THE
DEPARTMENT OF DEFENSE
AND THE
DEPARTMENT OF VETERANS AFFAIRS

(Pharmaceuticals, Medical Supplies and Equipment)

I. PURPOSE. This is a supplementary agreement to provide for the acquisition and supply support by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) for pharmaceuticals, medical supplies and equipment during national emergency. This agreement permits the VA to be recognized as a priority customer for these commodities consistent with DoD policies for prioritizing and allocating military readiness needs.

II. BACKGROUND. This agreement supplements the implementation of P. L. 97-194, Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act of 4 May 1982, in which VA will assist the DoD in the care of its military personnel wounded in combat or other active-duty personnel by offering the use of its health care facilities to DoD. Further, DoD and VA have been successfully participating in joint efforts since 1978 to procure and support both departments with pharmaceuticals, medical supplies, devices and equipment. Supply support arrangements during periods of national emergency have not been formally established.

III. AUTHORITY.

A. Economy Act of 1932, amended (31 USC 1535).

B. P. L. 97-174, Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act, dated 4 May 1982.

C. Agreement between the Department of Defense and Department of Veterans Affairs for Improving Purchasing and Supply Management of Medical Items and Non-Perishable Subsistence, dated 2 June 1978.

IV. A. The DoD Joint Materiel Priorities and Allocation Board (JMPAB) will establish, modify, and/or recommend priorities or allocation of materiel assets for the fulfillment of logistic requirements of U.S. and allied forces.

DRAFT

B. The Director of the Defense Logistics Agency (DLA) will be assigned as the DoD Executive Agent for this agreement.

C. The VA will provide representation to the DoD contingency planning process, as required.

D. The Defense Personnel Support Center (DPSC) will be delegated the authority to implement the provisions of this agreement with the VA designated counterpart.

V. PROCEDURES.

A. This agreement becomes effective upon formal notification of a national emergency, and at other times, it is used for planning purposes only.

B. The Secretary of Defense (Joint Chiefs of Staff) will provide notification of a national emergency through the respective logistic readiness organizations within DoD, DLA and VA.

C. DoD/DLA will provide VA with the UMMIPS policies, procedures, and the appropriate priority designations to be used for requisitioning pharmaceuticals and medical supplies, devices and equipment during periods of national emergency.

D. VA will:

1. As a prerequisite, participate with DoD in various emergency exercises and in the development and use of special systems needed in emergency situations.

2. Provide DPSC with anticipated projected requirements for pharmaceuticals and medical materiel to be used for wartime requirements planning based upon the casualty load provided by the Services.

3. Provide an annual update of required items upon request by DPSC.

4. Utilize DoD contracts and agreements for procurement of pharmaceuticals, medical supplies, devices and equipment during periods of national emergency.

5. Provide direct reimbursement to the contractors for merchandise purchased by VA medical centers.

6. Authorize DoD/DPSC to pass priority requisitions to the VA during periods of national emergency for priority items when DPSC stock is depleted and the VA has assets on hand in its wholesale stockage system.

DRAFT

E. DPSC will:

1. Include VA projected requirements for pharmaceuticals and medical materiels in the DPSC annual plan for national emergencies.

2. Provide VA with data regarding pharmaceuticals and medical materiels required to support additional patient specialty demands.

3. Include VA contingency requirements in the DoD contracts and agreements for the procurement of pharmaceuticals and medical materiels.

F. The Military Services Medical Department will:

1. Provide to DPSC and VA the anticipated casualty flow to be used in wartime planning.

2. Provide an update to DPSC upon request.

3. Participate with DPSC and VA in exercising the development and use of techniques and procedures that will be needed in an emergency situation.

G. VA and DPSC will promote continued development of automated interfaces between the DoD and VA supply systems, e.g., electronic data interchange and automated requisitioning processes (MILSTRIP/FEDSTRIP).

VI. REPRESENTATION.

Policy matters will be determined by the Director, DLA, as the Executive Agent for DoD and the Deputy Assistant Secretary of Acquisition and Materiel Management, as the Executive Agent for VA. Implementation and the resolution of operational problems will be the responsibility of each department's representative as shown below:

Department of Veterans Affairs
Deputy Assistant Secretary for
Acquisition and Materiel Management (90)
810 Vermont Avenue, N.W.
Washington, DC 20420
Telephone: (202) 233-3808

Department of Defense
Director of Medical Materiel (DPSC-R)
Defense Personnel Support Center/DLA
2800 South 20th Street
Philadelphia, PA 19101-8419
Telephone: (215) 952-5775

DRAFT

VII. EFFECTIVE DATE. This agreement will become effective upon signature by both parties and will remain in effect until terminated. Notification of proposed termination must be submitted in writing and must be provided at least 180 days prior to the effective termination date.

VIII. PERIODIC REVIEW. This agreement will be reviewed for adequacy and effectiveness at least annually and renegotiated as necessary.

SIGNATURES:

DEPARTMENT OF VETERANS AFFAIRS	DEPARTMENT OF DEFENSE
______________________________	______________________________
H. Robert Saldivar Deputy Assistant Secretary for Acquisition and Materiel Management	OASD (P&L)
Date: ______________________	Date: ______________________

DRAFT

DRAFT IGA V101(91)M-90026

INTERAGENCY AGREEMENT
BETWEEN THE
DEPARTMENT OF DEFENSE
AND THE
DEPARTMENT OF VETERANS AFFAIRS

(Subsistence)

I. PURPOSE. This is a supplementary agreement to provide for the acquisition and supply support by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) for subsistence during national emergency. This agreement permits the VA to be recognized as a priority customer for this commodity consistent with DoD policies for prioritizing and allocating military readiness needs.

II. BACKGROUND. This agreement supplements the implementation of P. L. 97-174, Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act of 4 May 1982, in which VA will assist the DoD in the care of its military personnel wounded in combat or other active-duty personnel by offering the use of its health care facilities to DoD. Presently many VA medical centers purchase subsistence from DoD and through DoD contracts. However, VA medical centers need assurance of support during periods of national emergency to fulfill their mission as a backup health care system. Support arrangements during periods of national emergency have not been formally established.

III. AUTHORITY.

A. Economy Act of 1932, amended (31 USC 1535).

B. P. L. 97-174, Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act, dated 4 May 1982.

IV. RESPONSIBILITIES.

A. The DoD Joint Materiel Priorities and Allocations Board (JMPAB) will establish, modify, and/or recommend priorities or allocation of materiel assets for the fulfillment of logistic requirements of U.S. and allied forces.

B. The Director of the Defense Logistics Agency (DLA) will be assigned as the DoD Executive Agent for this agreement.

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C. The VA will provide representation to the DoD emergency planning process, as required.

D. The Defense Personnel Support Center (DPSC) will be delegated the authority to implement the provisions of this agreement with the VA designated counterpart.

V. PROCEDURES.

A. This agreement becomes effective upon formal notification of a national emergency, and at other times, it is used for planning purposes.

B. The Secretary of Defense (Joint Chiefs of Staff) will provide notification of a national emergency through the respective logistic readiness organizations within DoD, DLA and VA.

C. DoD/DLA will provide VA with the UMMIPS policies, procedures, and the appropriate priority designations to be used for requisitioning of subsistence during periods of national emergency.

D. VA will:

1. As a prerequisite, participate with DoD in various emergency exercises and in the development and use of special systems needed in emergency situations.

2. Provide DPSC with anticipated projected requirements for subsistence commodities to be used in development of emergency planning.

3. Continue to reimburse DPSC for stock items, and make direct payment to contractors who direct delivery subsistence to VA facilities.

4. Utilize DoD contracts and agreements for procurement of subsistence during periods of national emergency.

E. DPSC will:

1. Include VA requirements for subsistence items in the DPSC annual plan for national emergencies.

2. Include VA contingency requirements in the DoD contracts and agreements for the procurement of subsistence items.

F. VA and DPSC will promote continued development of automated interfaces between the DoD and VA supply systems, e.g., electronic data interchange and automated requisitioning processes (MILSTRIP/FEDSTRIP).

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VI. REPRESENTATION.

Policy matters will be determined by the Director, DLA, as the Executive Agent for DoD and the Deputy Assistant Secretary for Acquisition and Materiel Management, as the Executive Agent for VA. Implementation and the resolution of operational problems will be the responsibility of each department's representative as shown below:

Department of Veterans Affairs
Deputy Assistant Secretary for
Acquisition and Materiel Management (90)
810 Vermont Avenue, N.W.
Washington, DC 20420
Telephone: (202) 233-3808

Department of Defense
Directorate of Subsistence (DPSC-H)
Defense Personnel Support Center/DLA
2800 South 20th Street
Philadelphia, PA 19101-8419
Telephone: (215) 952-2900

VII. EFFECTIVE DATE. This agreement will become effective upon signature by both parties and will remain in effect until terminated. Notification of proposed termination must be submitted in writing and must be provided at least 180 days prior to the effective termination date.

VIII. PERIODIC REVIEW. This agreement will be reviewed for adequacy and effectiveness at least annually and renegotiated as necessary.

SIGNATURES:

DEPARTMENT OF VETERANS AFFAIRS	DEPARTMENT OF DEFENSE
________________________	________________________
H. Robert Saldivar Deputy Assistant Secretary for Acquisition and Materiel Management	OASD (P&L)
Date: __________________	Date: __________________

DRAFT

10 JUN 1985

MEMORANDUM OF UNDERSTANDING BETWEEN
THE DEPARTMENT OF DEFENSE AND THE
VETERANS ADMINISTRATION

SUBJECT: Referral of Active Duty Patients to Veterans Administration
Medical Facilities (Except for Locally Negotiated Agreements)

I. PURPOSE: In furtherance of the purposes of Public Law 97-174, this memorandum is intended to: (1) establish reimbursement procedures for active duty military treated at VA medical facilities when their treatment is not otherwise governed by procedures established in a local agreement; (2) establish procedures authorizing VA medical care for active duty emergent patients who appear at VA medical facilities; and (3) provide for a uniform method of reimbursement in accordance with P.L. 97-174 for care provided under this agreement. This agreement does not supersede agreements already in effect or subsequently negotiated between individual VA and DOD health care facilities that may provide for different rates of reimbursement. In accordance with 38 U.S.C. 620A(d)(1), this agreement does not cover transfers of active duty military personnel to VA facilities for care or treatment of an alcohol or drug dependence or abuse disability.

II. BACKGROUND: Although many VA and DOD medical facilities have executed local agreements under P.L. 97-174 that involve furnishing direct health care on a referral basis, the Veterans Administration and Department of Defense Health Care Resources Sharing Committee have identified the need for agency and department-wide referral procedures that, in the absence of an applicable local agreement, would govern the transfer of active duty military inpatients from military or community hospitals to VA medical facilities and treatment of active duty military patients at such facilities for emergency care. This memorandum supersedes the 1981 Memorandum of Understanding concerning "Transfer of Active Duty Spinal Cord Injured Patients (SCI) from Department of Defense (DoD) Military Medical Treatment Facilities (MMTF) to Veterans Administration Medical Centers (VAMC) Except for Local Referrals".

III. AUTHORITY: This Memorandum of Understanding is entered into pursuant to Section 3 of Public Law 97-174 (1982) (codified at 38 U.S.C. 5011(d)), and Section 3-105 of the VA/DOD Health Care Resource Sharing Guidelines set forth in a Memorandum of Understanding between the Veterans Administration and the Department of Defense.

IV. DURATION:

1. This agreement will remain in force during the period stated unless terminated at the request of either party after thirty (30) days notice in writing. To the extent that this contract is so terminated, DoD will be liable only for payment in accordance with provisions of this agreement for care provided prior to the effective termination date.

2. In the event of war or national emergency, this agreement may be terminated immediately upon written notice by the Department of Defense.

V. REIMBURSEMENT AND BILLING:

1. Reimbursement to VA medical facilities will be at the interagency rates established according to OMB Circular A-11, Section 13.5(a) and in effect at the time care was provided. Because the interagency rates do not include the cost of transportation or prosthetics, the actual cost of these services will be billed in addition to the interagency rates.

2. Charges for services provided to active duty personnel under terms of this agreement will be prepared monthly, on plain bond paper, in multiple billing format for each branch of the DoD. The statements of charges, accompanied by copies of supporting documents such as authorizations and/or VA Form 10-10, Application for Medical Benefits, will be submitted with a covering SF-1080 through Fiscal Service to the respective military payment center. The charges must contain, at a minimum, the name, rank or rate, SSN, the type of care provided, including dates of admission, discharge, and/or outpatient treatment, and the condition for which medical care was given for each active duty person provided medical care during the month.

VI. VA/DOD RESPONSIBILITIES: See attachments 1 and 2.

Attachments:
1 - VA Responsibilities
2 - DOD Responsibilities

John W. Ditzler
JOHN W. DITZLER, M.D.
Chief Medical Director
Veterans Administration

William Mayer MD
WILLIAM E. MAYER, M.D.
Assistant Secretary
of Defense (Health Affairs)

VA Responsibilities:

1. Provide DoD, ASMRO, and JMROs with an updated, at least annually, list of VA resources services, including addresses and telephone numbers of SCI centers, blind rehabilitation centers, and those VA facilities with head injury treatment capabilities.

2. Assist military authorities in arranging transfers to:

   a. VA facilities of active duty members. Includes verification of acceptance, providing an assessment of the VA's capability to manage the course of treatment or rehabilitation of members, discussion of any special circumstances, and coordination of transportation arrangements.

   b. VA designated community nursing homes of active duty members. When a member has received the maximum benefits of hospitalization but requires nursing home type care, arrangements may be made by the VA for direct placement of such a patient in a community nursing home. Such a transfer may be arranged for patients requiring such care who are in USMTFs, community hospitals, or in VA facilities.

3. Render the full range of treatment and/or rehabilitative services available at the accepting VA facility to all active duty members (except alcohol and drug patient care) accepted by a VA facility under this MOU, provided such acceptance does not adversely affect the range of services, the quality of care, or the priorities for care established by law for all VA beneficiaries.

4. Arrange and be responsible for providing local ground transportation of active duty members to VA facilities from local airfields when the patient is being transferred directly from an overseas USMTF or when specifically requested by a uniformed services medical authority.

5. Provide notification to the appropriate Army or Air Force MTF or the appropriate Navy OMA (Office of Medical Affairs) when a member, still on active duty, is to be released from a VA treatment or rehabilitation program.

6. Provide immediate notification to the appropriate Army or Air Force MTF or the appropriate Navy OMA when an active duty member is admitted.

7. For Spinal Cord Injury, Head Injury, and Blind Rehabilitation patients, conduct and process medical boards when requested by the military authority having cognizance over the member.

DOD Responsibilities:

1. MTF commanders will provide notification to ASMRO (through JMRO for overseas) when seeking to transfer a routine or nonemergent active duty patient from either a USMTF or from a civilian hospital. Notification will be made by telephone, message or the Defense Medical Regulating Information System (DMRIS), where available. ASMRO (through JMRO overseas) will provide notification to the military activity identifying the VA facility agreeing to accept the member. If the patient is moved by other than Air Force aircraft or is an emergency patient, information reported to ASMRO will be the minimum required to allow ASMRO to develop referral patterns (refer to Chapter 4, Joint Regulation, dated ____________, entitled MEDICAL REGULATING TO AND WITHIN THE CONTINENTAL UNITED STATES). For emergency patients only, this notification may be made after the fact. (See Page 2-2 for transfers of Spinal Cord Injury, Head Injury, and Blind Rehabilitation Patients.)

2. Following MTF notification by ASMRO of the VA facility agreeing to accept the patient, military authority personnel will establish the most expeditious means of contact via telephone, message or DMRIS, where available, with their counterparts at the designated VA facility to make arrangements for transfer. The initial contact shall verify acceptance, provide medical information regarding the patient, and coordinate transportation of the patient from point of origin to the destination VA facility.

a. For intra-CONUS transfers of patients by air, the MTF commander is responsible to coordinate ground transportation from the airfield to the VA facility. Unless an agreement is already in effect that provides for local transportation, the originating USMTF shall make arrangements with any USMTF within a reasonable distance to provide needed transportation. If commercial transportation is required, the originating treatment facility will reimburse the cost. The transferring USMTF shall make arrangements 24 hours in advance with the VA facility to provide civilian transportation from the airfield, if necessary.

b. For transfers from outside the United States, the referring military authority may use telegraph (Western Union), message or DMRIS, where available, to communicate with the receiving VA facility should telephonic communication be difficult. The VA facility designated to receive the patient shall arrange and be responsible for providing local transportation of patients from the local airfield to the VA facility. When necessary, such patients may be sent to USMTFs prior to going to the accepting VA facility. The accepting USMTF will be responsible for arranging transportation of patient to the destination VA facility.

3. Provide notification, telephonically and in writing, to VA facilities when active duty members, referred for care while anticipating separation from service, are discharged or released from active duty. This notification shall be made prior to the date of separation and will include the date and type or character of separation and the periods of active duty served.

4. For emergency situations, expedite transfers from USMTFs or civilian hospitals to VA facilities through telephonic communications exclusively. If movement is required through the aeromedical evacuation system, CONUS MTFs will report directly to the Patient Airlift Center, Scott AFB, Illinois. For overseas, MTFs will report to the 2nd Aeromedical Evacuation System for European transfers or 9th Aeromedical Evacuation System for Pacific transfers. An after the fact report will be made to ASMRO within 48 hours.

THE FOLLOWING GUIDELINES ARE ADDED REQUIREMENTS FOR THIS SPECIAL CATEGORY:

SPINAL CORD INJURY PATIENTS, HEAD INJURY, BLIND REHABILITATION:

1. Expedite transfers directly from USMTFs or civilian hospitals to VA facilities through telephonic or DMRIS, where available, contact exclusively without regards for holidays and weekends. ASMRO will provide assistance on what VA facility has the capability to provide care and is closest to member's selected place of residence. If assistance by ASMRO is not required, an after the fact report will be made within 48 hours. Each Surgeon General's office, or his designee, shall provde a 24 hour a day, seven days a week point of contact should problems arise.

2. Ensure that the goal of effecting SCI transfer within three days (four days from overseas) is met whenever possible.

3. When possible, assure that spinal cord injury, head injury, and blind rehabilitation patients arriving from overseas are transported directly to the VA facility without passing through intervening USMTFs.

4. Assure that spinal cord injury, head injury and blind rehabilitation patients transferred from community hospitals are also transported directly to a VA facility, whenever possible.

5. Assure that each Surgeon General's office, or his designee, provides necessary assistance to VA facilities in the VA's conduct and preparation of medical boards.

QUESTION: 7. In authorizing VA to provide care to members of the armed forces in war or national emergency, Public Law 97-174 authorizes VA to transfer certain veteran patients to contract facilities. A VA official who briefed the staff of this Committee on January 4, 1991 on VA/DOD contingency planning advised that VA could make some 18,000 beds available to DOD within 72 hours (and some 25,000 beds ultimately) for the care of DOD casualties. In responding to the question, did VA have a system in place for transferring thousands of veteran-patients to community and other VA facilities, the spokesman stated that such transers were "no problem" and that "routine" placement procedures would be used. Is it the VA's position that existing, routine procedures will satisfactorily serve to outplace thousands of patients within hours of the airlifting of injured troops from oveseas, and that no special steps need be taken to assure appropriate, safe, and timely transfer? If not, what steps is VA taking to assure that outplacements of this magnitude will take place smoothly?

Answer: The VA spokesman was addressing the normal peacetime mode only and stated that "routine outplacements were going on daily utilizing existing resources and this is not a problem", i.e., during peacetime. VAMC's have discharge planning boards which routinely decide outplacement. To the extent feasible, this process would continue in a contingency activation but at a greatly accelerated pace and using special authorities provided for under 5011A, Title 38, U.S.C.

Question: 8 Please furnish us your projections of the costs associated with VA's arranging with community facilities and through fee-basis arrangements with community clinicians to continue to provide for the continued care of veteran patients displaced from VA medical facilities in the event that a conflict in the Gulf erupts and VA faces whatever "worst case" scenario it has been planning for. Please furnish as well your projection of the costs associated with providing such community care to veterans who seek care from VA facilities in the weeks after any "triggering" of the VA/DOD contingency system and who are eligible to receive community-based care under 38 USC sec. 603. Please provide as well the assumptions and methodology on which both sets of projections are based.

Answer: The projected budget impact of providing continued care of veteran patients displaced related to Desert Storm is dependent upon information such as the numbers and types of patients that the VA would receive from the Department of Defense (DoD) that is unavailable at this time. In determining the actual budget impact of Operation Desert Storm, the VA will: (a) Compare the contract care costs of displaced VA patients to in-house costs, (b) compare the costs of care provided to DoD patients to DoD reimbursement; (c) Identify training and administrative costs; and (d) identify the net effect of the costs and savings associated with VA personnel who are activated to military duty. The analysis of the information from (a), (b), (c), and (d) above will be the basis for identifying the budget impact of the VA/DoD Contingency System on the VA medical care system.

Question: 9 Please furnish us with your projections (and associated assuptions and methodology) of any other costs which VA anticipates and which are attributable to VA's contingency support of Operation Desert Shield.

Answer: Another area of financial impact deals with the preparation to treat casualties. VA has and is continuing to train medical center personnel concerning special care that could be expected with treating casualties of Operation Desert Shield, i.e., treatment relating to chemical and biological warfare. To date, the impact of centralized training has been $572,000, which is directly attributable to costs associated with travel, training material, instructors, etc. Additional centralized training is presently planned and will have further budgetary impact, estimated to be $205,000. VA is presently in the process, and will shortly have in place, a report whereby facilities will itemize actual cost associated with readiness, for example, retrofitting buses to transport casualties. VA will continue to track the cost associated with preparation and will do so on an actual cost basis.

Question: 10 What is the most current number of military casualties VA is advising DoD it can care for in the 24-, 72-, and more than 72-hour time frames? Assuming VA is projecting a capability of hospitalizing 18,000 or more casualties within days after a DoD request for support and transferring many of its veteran patients to other VA or community facilities, what are VA's projections as to the impact in the weeks and months thereafter that such an undertaking will have on such VA facilities' capability to provide hospital care to Category A veterans and outpatient care to those service-connected and low-income veterans to whom VA "shall" provide service? Please specify the assumptions you are making in answering this question.

Answer: VA Medical Centers are reporting available beds to the Emergency Facility Operations Center at Martinsburg, West Virginia. The figures are reported on a daily basis. As of January 15, 1991, the following number of available beds were reported:

Within 24 hours	Within 72 hours	72 hours - 1 month
10,293	14,592	25,000

Bed reporting reflects the number of patients who could be discharged, the number of patients who could be transferred to another VAMC or a non-VA hospital and the impact of the loss of VA reserve personnel who may be called up or who volunteer. No beds are being reported that cannot be fully staffed.

Top priority for VA hospital admission will be given to emergencies, service-connected veterans, and DoD casualty referrals. NSC veterans for whom VA hospitalization is mandated by law, who apply for and are found to be in need of such care, will be offered a bed within the VA system, if available. Nursing home care is not mandated for any category. Admission of all veterans for whom hospital care is discretionary will be curtailed, except for emergencies when patients cannot be safely transported.

The top priority system for providing outpatient care will be enacted as follows: outpatient care would be provided to service-connected veterans; nonservice-connected veterans would be provided outpatient treatment on a space and resource available basis. Outpatient care for veterans in the discretionary categories would be curtailed, beginning with the lowest category. Depending on the medical specialty, certain clinics may be closed to all discretionary outpatients in order to accommodate SC, DoD casualty, and low income NSC veterans. Discretionary category veterans discharged from care or not accepted for care will be assisted with referral to community resources.

Question: 11 What impact will a VA contingency support role have on veterans' access to care at VA facilities in Florida, and other "sunbelt" areas, where service-connected veterans comprise a disproportionately high percentage of the patients served? In that regard, Public Law 97-174 provides (as codified at 38 USC sec. 5011A(a)(1)) that the Secretary may give a higher priority to furnishing care to members of the armed forces during and immediately following a period of war than to any other group of persons eligible for VA care "with the exception of veterans with service-connected disabilities." Are we correct in assuming, therefore, that VA medical facilities in Florida, for example, are reporting only very limited capability to provide beds for contingency support purposes, and will play only a very limited role, if any, in admission and care of DoD personnel?

Answer: We do not anticipate that the "sunbelt" hospitals will have a substantially different role than hospitals in other areas of the country when it comes to contingency support. The obligation to support veterans with service-connected disabilities will cause a bit more difficulty for some hospitals, primarily in Florida and Texas, but the percentage differences in service-connected veterans between Regions, especially on inpatients, does not have such a wide variance that it would make it impossible for hospitals in these areas to meet their obligations to the contingency plan. For instance, between October 1, 1989, and July 31, 1990, the percentage of discharges in the old Region 3 (which includes the Florida hospitals) which were for service-connected veterans being treated for any condition was 42% of the total discharges. Although this was the largest percentage of any Region, the same percentage for the Region with the lowest number of service-connected discharges (old Region 4) was 34%. There is a slightly larger percentage spread on outpatients. For example, the five Florida hospitals show approximately 378 beds available for DoD support within 24 hours of notification.

Question: 12 Has Central Office emphasized to field facilities the priority standing which service-connected veterans enjoy relative to armed forces personnel? If so, please provide a copy of any guidance or directive to that effect more recent than Circular 10-88-116 (October 4, 1988).

Answer: VHS&RA has emphasized the requisite priorities for care in several recent nationwide teleconferences directed to all VA medical facilities. In addition, a detailed VA/DoD Contingency Operations Plan has been developed by VHS&RA and is being distributed to each VA Medical Center as of January 17, 1991. A copy of this plan will be forwarded to the Committee.

Question: 13. Please furnish this Committee a copy of the report to the Secretary of the "blue ribbon" Advisory Committee for Health Research Policy.

Answer: The Advisory Committee for Health Research Policy will submit its final report to Secretary Derwinski by January 23, 1991. A copy of the report will be sent to Chairman Montgomery as soon as it is available.

Question: 14. An apparent shift in the marketing strategy employed by the manufacturer of the drug clozapine suggests that this drug could become available to VA in the near future under terms satisfactory to VA. (In so speculating, we assume, however, that VA will not accede to demands that it purchase this drug at prices in the range of $4000-5000, a range suggested in recent press reports, and one which in our view remains exorbitant.)

Are we correct, in any case, in assuming that the VA's medical care budget for FY 1992 could not, and did not, take into account the cost of procuring that drug?

Answer: That is correct. The medical care budget did not take into account the anticipated expenditures for clozapine.

Question: Assuming further that negotiations with the manufacturer of that drug proceed satisfactorily, what additional costs do you foresee VA incurring in FY 1992, and in the outyears, for the drug itself?

Answer: The manufacturer of clozapine has recently expressed a willingness to market the drug without its redundant monitoring services at a reduced (median) cost of $4160/patient/year.

VA has made a conservative estimate that there may be at least 9,000 candidates for clozapine in the VA system currently. Even if only 40 percent of these are helped by clozapine (as suggested in the United States clozapine trials) this would mean 3600 veterans would be on long-term clozapine treatment at a recurring cost of nearly $15 million annually for medication alone. This is a conservative figure which does not reflect the additional trial use of the drug in the other 60 percent of patients who have not responded to other treatment. This additional expense could reach nearly $11 million.

VA estimates that outyear expenditures for clozapine will continue at the same rate if not slightly higher. Estimates of additional costs for the drug in the outyears are difficult due to the lack of diagnostic-specific workload data. While VA's data base includes information on the number of discharges for schizophrenia, it does not contain data on the number of outpatients treated for schizophrenia. There will be an unknown number new clozapine patients applying for VA care through referrals from private and public health care systems which are unwilling or unable to provide clozapine.

Question: Does your staff anticipate that administration of this drug will permit VA to discharge significant numbers of hospitalized chronic schizophrenics?

Answer: Based on reports in the clinical literature, approximately 10 to 15% of patients responsive to clozapine treatment may be discharged from long-term inpatient care. This represents approximately 360-540 patients under VA care. The anticipated figures representing cost savings for inpatient care are derived from the ability to close whole wards. This will not be the case with clozapine, as the improved patients will come from VAMCs across VA's healthcare system.

The outcome of clozapine therapy, as measured by discharges and need for outpatient care, is still a matter of controversy due to the limited size and scope and potential bias of current studies. VA is considering a multi-site outcome study that should clarify the impact of clozapine treatment of VA patients including discharge and followup issues. This study may be instituted if VA and Sandoz can reach agreement on a clozapine contract.

Question: If so, will the requirements to monitor such patients and provide them outpatient treatment and support result in VA incurring additional outpatient workload.

Answer: Yes. While the quality of life for clozapine patients may greatly improve in some cases, most of those discharged will require still significant outpatient follow-up and routine medical care by VA. There will be no inpatient "savings" from these discharges as beds made available by the discharge of clozapine patients will be filled by other psychiatric patients with schizophrenia and other mental disorders.

Question: If so, what are the fiscal and program implications in FY 1992 and beyond associated with procuring and initiating clozapine therapy at VA medical facilities?

Answer: The net system fiscal implications of clozapine therapy will be a large increase in pharmaceutical expenditures (see 14(a)), an increase in outpatient workload (see 14(d)), and essentially no net change in inpatient psychiatry workload.

Question: 15. This committee has championed VA interests in sending strongly worded letters to the Secretary of Health and Human Services (HHS) and the Director of the Office of Management and Budget aimed at reversing a key element of HHS' implementation of the Medicaid Prudent Pharmaceutical Procurement Act. Those letters urged HHS to exempt VA's Federal Supply Schedule prices from the Act's "best price" benchmark. I urged HHS to act in large measure out of a concern with the likelihood that pharmaceutical manufacturers would act to protect profit margins at the expense of the VA and the Department of Defense. Although the Committee is aware that VA urged manufacturers to extend expiring Federal Supply Schedule contracts for an additional three months, we would appreciate a status report on this situation, and your most current projections of the fiscal impact this problem will have on VA in FY 1992 if it is not satisfactorily resolved.

Answer: FSS drug contractors provided positive responses to VA's request for an extension of the contracts expiring December 31, 1990. Replacement contracts are in the process of being awarded and will be in place by March 31, 1991. The combination of contract extension and newly awarded contracts should provide coverage for the drug and pharmaceutical products used by VA as well as those for backup to Desert Storm.

With the extension of the 1990 contracts by many manufacturers, VA does not currently have enough data to fully assess the impact. However, there are examples of significant price increases in the 1991 contracts that have been awarded. Of equal concern is that contractors may exercise their cancellation rights on contracts if they determine that it is to their advantage to do so due to the rebate provisions of the Act. VA remains highly concerned that the Act will result in significant cost increases in VA pharmaceutical expenditures, if Federal Supply Schedule contract prices are not protected. As required by the legislation, VA will be conducting a comprehensive study of the effect on prices as soon as adequate data are available and will be pleased to share its findings with the Committee.

Question: 16 Please provide the Committee an analysis on veterans' use of "HISA" benefits (under 38 USC sec. 617). What has been the pattern of veterans' use of this benefit? Have nonservice-connected veterans (who are eligible for a maximum grant of $600) tended to apply the grant to home improvements and structural alterations of a different nature than service-connected veterans? As to SC and NSC veterans respectively, what have been the average costs veterans have incurred for home improvements and structural alterations to which they have applied these grants? What have been the higher cost items as to NSCs and SCs respectively, and what have been the ranges of costs for those higher cost items veterans around the country have incurred. What has been VA's experience as to veterans' failure to avail themselves of this benefit because the dollar limits remain at levels set in 1976? If systemwide data is not available or readily accessible to answer questions regarding HISA benefits, please furnish such data as may be gathered through surveying an appropriate number of geographically dispersed medical centers.

Answer: Veterans may request benefits for a wide range of improvements. Most frequently, requests are received for widening doorways for wheelchair access, construction of wheelchair ramps, modification of bathrooms, and kitchens. Nonservice-connected veterans who are eligible for a maximum grant of $600 have not tended to apply the grant to home improvements and structural alterations of a different nature than service-connected veterans. The usual usage of the nonservice-connected veteran is the maximum allowable of $600. The service-connected veteran costs usually run at approximately the maximum allowable of $2500. Some costs for service-connected veterans are in excess of $2500; in these cases, the veteran pays the difference. Bathroom renovations, ramps to houses, and stairway lifts are usually the most expensive improvements done under this program. These types of improvements are done for both service-connected and nonservice-connected veterans equally. These improvements may run from $1500 to $3500 on the average. Veterans do not fail to avail themselves of this benefit due to funding limitations. If improvements needed are in excess of what can be granted, the veteran pays the difference.

CONGRESSMAN MONTGOMERY

Question: 1. In view of the severe fiscal constraints experienced by the National Cemetery System, will you be able to accommodate casualties resulting from Operation Desert Shield. What effect will this have on your day-to-day operations?

Answer: The National Cemetery System is prepared to serve the families of any member of the armed forces who dies on active duty. The ability of the National Cemetery System to accommodate Desert Storm fatalities without substantial impact on normal operations will depend largely on the number of fatalities involved. Cemeteries located in highly metropolitan areas may experience a much larger increase in workload. Priority policies and accommodations (including weekend and holiday burials) for all national cemeteries, as well as for headquarters activities with oversight of field operations and for processing and delivery of headstones and markers, have been developed and are being implemented. It is too early to project whether the implementation of these policy changes will result in additional costs for overtime and other operational expenses to the National Cemetery System.

Question: 2. Public Law 101-508 repealed the provisions contained in Title 38 which restore the benefit eligibility for remarried surviving spouses if the remarriage is terminated by divorce or death. Is the Cemetery System one of the benefits affected?

ANSWER: Yes, one of the benefits affected by Public Law 101-508 was the right of these individuals to be buried in a national cemetery. Since the legislation became effective on November 1, 1990, the NCS has experienced minimal impact. However, the number of surviving spouses impacted could be substantial during the next 5-10 years, based on actuarial data.

CONGRESSMAN MONTGOMERY

Question: 1. During fiscal year 1989, a service-connected disabled veteran waited an average of 100 days between the time his or her application for vocational rehabilitation was received in the Department of Veterans Affairs (DVA) and the time of the veteran's first appointment with a counseling psychologist.

What steps will you take, in the event of war in the Middle East, to ensure that those disabled during the Desert Shield action are quickly provided vocational rehabilitation services?

In the event that significant numbers of individuals require vocational rehabilitation services as a result of Desert Shield, what will be the impact on services provided to our current vocational rehabilitation eligibles?

Answer: Vocational Rehabilitation and Counseling staff will make providing services to individuals disabled during Desert Storm action first priority. We will continue to work closely with our counterparts within VA and the rehabilitation profession; e.g., VHS&RA, Vet Centers, Veterans Services Divisions and State Rehabilitation Organizations. VA's Veterans Services Division will provide primary outreach services, supplying VR&C staff the names of veterans injured as a result of Desert Shield/Storm. VR&C staff will, as it traditionally has, provide personal orientations to rehabilitation services with these individuals at VA, DOD and other medical facilities. These veterans will receive priority treatment and be scheduled for evaluations as follows:

1. Servicepersons who are severely disabled as a result of Desert Shield/Storm.
2. Veterans who are severely disabled but not involved in Desert Shield/Storm.
3. Veterans who are not severely disabled but are disabled as a result of Desert Shield/Storm.
4. Veterans who are service-disabled but not severely so and not as a result of Desert Shield/Storm.
5. Spouses and children who qualify for services under Chapter 35.

In the event that significant numbers of individuals require vocational rehabilitation services, VR&C staff will have to further adjust the type of services provided to existing clients. We would expand the use of the contracting out provision available for educational/vocational counseling for individuals eligible for services under all chapters other than Chapter 31. We would provide face-to-face assistance only as needed and/or requested by Chapter 31 veterans pursuing a vocational rehabilitation program thereby insuring that veterans who need assistance will get assistance. Depending on the severity of the increased workload evolving from Desert Shield/Storm, motivation, clerical, case management, quality assurance and other functions would be significantly modified or curtailed.

VA's General Counsel has held that basic entitlement to Chapter 31 Vocational Rehabilitation services and assistance under 38 U.S.C. section 1502(1)(B) is limited to members of the Armed forces hospitalized pending discharge if such persons are in a hospital over which the Defense Department has control. In other words, under existing statute, we are unable to provide rehabilitation services to servicepersons in VA medical facilities. The Congress is aware of the effect of this statutory provision and legislation is pending which would expand its scope to include persons hospitalized or receiving medical treatment from VA and other medical facilities. Legislation would also be necessary to enable the Vocational Rehabilitation Service to expand contracting for counseling and evaluation services required in connection with the temporary program of vocational training for certain pensioners under section 524 of Chapter 15, precluding the need for face to face evaluations by VR&C staff.

We are currently working on providing contemporary information to VR&C field staff on effective techniques for providing rehabilitation services to individuals who have sustained combat injuries from chemical/biological agents and burns, especially how to adjust to these combat injuries.

Question: 2. The Veterans Services Division, which is the primary agent for the provision of outreach services to veterans and their dependents, has long been understaffed. As example, during fiscal year 1990, no veterans benefits counselors were available for direct interviews in 24 of the 75 largest metropolitan areas.

In the event of a wave of activity generated by Operation Desert Shield, what steps are being taken to ensure that Veterans Services is able to provide the necessary associated services?

Answer: It has been over fifteen years since our efforts had to be directed to the immediate needs of persons disabled from or readjusting from wartime experience. During these years, we have attempted to maintain service to active military through our liaison and briefing activities at military installations. In the past two years we have concentrated heavily on improved information dissemination to active duty personnel.

During recent months we have developed extensive information regarding benefits eligibility and impact for persons serving on active duty or called to active duty as a result of Operation Desert Shield. This information has been shared with regional offices, military officials and other interested parties.

In the event of combat operations, VBA has prepared a contingency plan for regional office operations. The highest priorities will be given casualty assistance services, services to disabled servicemembers, military liaison services and transition assistance.

General guidance has been given to assist in redirecting field station resources to the above priorities, to include suspension of low priority activities and timeliness standards.

CONGRESSMAN MONTGOMERY

Question 1: Please furnish the Committee a copy of any report or analysis being prepared by the Office of Inspector General on "VA/DOD Contingency Planning" and any related report or analysis being prepared by that office regarding the VA's Emergency Facilities Operations unit at the Martinsburg VAMC.

Answer: The VA Office of Inspector General has prepared an information paper on VA/DOD contingency plans, which was provided to the House Veterans Affairs Committee on January 18, 1991. The information paper included a review of the Emergency Facilities Operations site at VAMC Martinsburg, WV.

VA OFFICE OF INSPECTOR GENERAL

INFORMATION PAPER

VA/DoD CONTINGENCY PLANS

Reported to the Senate Veterans Affairs Committee

January 17, 1991

- Amended Page 7 January 18, 1991 -

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Introduction

The Office of Inspector General in accordance with the January 9, 1991, request of the Chairman, Senate Veterans Affairs Committee conducted a limited review of the VA/DoD Contingency Plan. The review was conducted at selected medical centers, medical region offices, supply depots, and Central Office (including the Emergency Facilities Operations site at VAMC Martinsburg, WV) during the period January 9 through January 14, 1991. Our review continued at VA Central Office through January 15 and 16 to cover the initial implementation of a new VA/DoD Contingency Plan reporting system. The review was performed to provide the Committee and VA officials with a quick assessment of the validity of certain elements of the plan. This information package presents the results of the review. A further analysis will be considered as time and resources permit.

OFFICE OF INSPECTOR GENERAL

INFORMATION PAPER

VA/DoD CONTINGENCY PLANS

Authority

- o **P.L. 97-174 (38 USC 5011A) "Furnishing of health care services to members of the Armed Forces during a war or national emergency"**

- During and immediately after a period of war or national emergency DoD might not have adequate health care resources.
- VA has an extensive, comprehensive health care system that could assist DoD.
- VA may give higher priority to serving active duty personnel than to veterans during such a period except to service-connected veterans.
- VA is authorized to enter into contracts with private facilities to provide care and services subject to availability of appropriations and reimbursement.
- The cost of care or services shall be reimbursed by DoD at agreed upon rates.
- VA and DoD shall enter into an agreement to plan and establish procedures for implementation of the law by November 1982.
- Plans shall be completed and submitted to Congress by May 1983.
- VA and DoD shall jointly review the plan annually and report modifications within 30 days.
- VA shall report to Congress within 30 days after declaration of war or national emergency the allocation of facilities and personnel needed to provide priority hospital, nursing home care and medical services to members of the Armed Forces.

Implementation

- o **VA/DoD Memorandum of Understanding dated December 4, 1982**

- Facilities of VA will be available as the principal support to the DoD health care system when DoD does not have adequate medical resources to meet medical contingencies.

- VA facilities will be managed by VA throughout an emergency period.
- VA will provide care upon request of DoD in accordance with plans.
- The Chief Medical Director will represent VA in coordinating plans with DoD.
- The approved annual DoD plan shall be forwarded to VA for review.
- Based on the DoD plan for its military medical facilities, the Chief Medical Director will develop a VA Contingency Plan in support of military medical facilities.
- The VA Contingency Plan will be based on a bed availability assessment projecting the number, type and location of VA beds which could be made available to support the treatment of military personnel in the event of war or national emergency.
- The bed availability assessment will take into account the impact upon VA operations of a call-up of Ready Reserves.
- The approved annual VA plan will be forwarded to DoD for review.
- Modifications to approved plans will be reported to Congress within 30 days.
- VA and DoD will coordinate publication of directives pertaining to the plans.
- VA may, upon request, authorize DoD to use VA medical facility resources to help develop and implement VA plans.
- DoD will reimburse VA in accordance with rates agreed upon based on the cost of services provided.

o **VHS&RA Policy (Circular 10-88-116, dated October 4, 1988)**

- Each medical center must be prepared to provide at least 25 percent of staffed operating beds within 72 hours.
- Each VAMC will submit an annual contingency plan to be reviewed by the regional directors and submitted to the Office of Emergency Facilities Operations by December 31st each year.
- VA facilities are designated as Federal Coordinating Centers, primary receiving centers, secondary support centers and base/installation support centers.

- A standardized reporting system to DoD for VA bed availability by facility is adopted which incorporates 8 DoD patient evaluation categories and includes tracking VA employees subject to mobilization.

- Assumptions:
  - (1) planning will be based on existing staffing, supplies and other resources;
  - (2) staffing will be diminished by mobilization of VA employees;
  - (3) CONUS military hospitals will meet capacity in 48 hours, with a majority of subsequent work referred to VA and civilian facilities; and,
  - (4) casualties could arrive at VA facilities within 24-48 hours.

- Generally DoD will provide initial transportation of military casualties through Federal Coordinating Centers (34 VA, 40 DoD and 1 private) to VAMCs and civilian hospitals.

- Supply Service at each VAMC normally maintains a 45-90 day stock of medical supplies.

- A disaster item listing is maintained and updated weekly at VACO to position and deploy supplies quickly from depot stock to VAMCs.

- Charges for services will be prepared monthly and forwarded to VACO for consolidation and submission to DoD for reimbursement.

- Costs for transfer of VA beneficiaries to non-VA hospitals are the responsibility of local VAMCs.

- VACO will assess local medical facility impact on funding and staffing in order to respond to increased workloads.

- An exercise of local contingency plans will be conducted annually.

- A self assessment guide is provided for local VAMC use for preparation of the plan.

- Reporting formats for medical centers, medical districts and nationally are provided.

Program Developments

- The Secretary of Veterans Affairs activated the VA/DoD contingency plan August 29, 1990.
- Approximately 12,500 VA employee reservists have been identified, including 1,000 physicians and 2,300 nurses.
- Training initiatives for VA health care providers were identified with a focus on infectious diseases, exposure to chemical weapons and combat stress.
- Communications between key VA offices in Minneapolis, MN, Martinsburg, WV, 34 Federal Coordinating Centers and Scott AFB, IL were improved by installation of dedicated telephone lines.
- VA/DoD Contingency Plan Reporting Software, Version 1.0 to be activated in January 1991, provides for:
    - direct reporting by VAMCs to the plan's data base at Martinsburg;
    - each facility report to incorporate planned bed availability, bed availability/status data, employee mobilization impact data, patient transfer data and secondary support site data;
    - edit capability by responsibility levels and facility type; e.g., primary facilities reporting to DMRIS, regional office review to edit site data, etc.;
    - controls to identify absent reports/facilities; and,
    - summary reports for bed status by region and nationally, mobilization impact, patient transfers, etc.
- VHS&RA organizational and policy initiatives have been implemented to clarify responsibilities.
- Development of a draft national planning document was completed in January 1991 to incorporate organizational and policy initiatives for all operating levels that evolved over the past 6 months.

SVAC Concerns

o Concern 1. **Does the mechanism through which VA facilities report the number of staffed beds that could be made available throughout the VA system reliably identify the numbers of staffed beds, by appropriate category, that could be provided within 24 hours and 72 hours and beyond 72 hours after the onset of an emergency?**

- Methodology: We performed a two-step review, a top-down review of national data and a bottom-up review at selected medical centers in order to address the Committee's concern. Our analysis of national data was made to determine whether VHS&RA has the capacity in its medical care system to meet commitments to DoD. Our analysis of local medical centers was made to assess the reliablity of data reported to DoD.

Analysis of National Data

- Our review of VHS&RA's national bed census data indicates that VHS&RA could meet its overall commitments to DoD but not necessarily at the specific medical centers and in the categories reported to DoD. For example, VHS&RA's Summary of Medical Programs Report shows the following data for general and service-connected (SC) bed availability in Fiscal Year 1990:

VHS&RA Bed Availability Data (000)

Total Operating Beds	70,000
Average Daily Census	47,000
Average Length Of Stay	18 days
SC Veterans Admissions	217,000

- Based on VHS&RA's national bed availability data, 23,000 beds were vacant and available on an average day in FY 1990 (70,000 - 47,000). When the average daily census of 47,000 is divided by the 18 day average length of stay for all inpatients, a total of 2,600 additional beds are made available each day because of normal patient discharges. Therefore, with no new admissions, a total of 30,800 beds would be available within a 72 hour period (23,000 + 3 days x 2,600). This total would be reduced by admissions of service-connected veterans who have priority for treatment under P.L. 97-174. An average of 600 service-connected veterans are admitted daily (217,000 divided by 365 days). Therefore, 72 hour bed availability would total about 29,000 (30,800 - 1800).

- We believe bed availability would continue to increase for some time under this scenario with admissions restricted to SC veterans. Also, program officials informed us that humanitarian admissions for other than service-connected veterans would continue; however, we believe such admissions would probably not be material for these calculations.

- VHS&RA officials stated that any calculations should be based on 82 percent of total operating beds since they believe funding to support operations is optimal at that level. While we are unaware of any Agency policy that reflects this criteria, it does reflect the judgement of operating officials. Using the same calculations described previously a total bed availability of 16,500 could be achieved in 72 hours at 82 percent of reported operating beds. This bed availability total would be 1,000 beds less than the current VHS&RA goal.

- VHS&RA's policy of providing 25 percent of staffed operating beds within 72 hours is essentially met under either scenario since the 17,500 bed goal (25 percent x 70,000) is exceeded by a factor of one and one-half at full operating bed levels and is 94 percent of goal using the 82 percent operating bed level. Therefore, we believe that VHS&RA could reasonably meet its obligations to DoD in terms of overall system capacity.

Analysis of Medical Center Data

- Our review of data reported to DoD by the Emergency Facility Operations Site at Martinsburg, WV, for four medical centers (Milwaukee, WI; West Los Angeles, CA; Manchester, NH; and Hines, IL) shows these centers probably could not have met bed availability projections for the following reasons:

  - - Milwaukee: On January 9th, Martinsburg reported that the center could make available 535 beds on 24 hours notice. We found that on that date the center had a total of 518 beds staffed and supported. The hospital reported to our on-site team on January 11, that a total of 134 beds could be made available to DoD within 72 hours.

  - - Manchester: On January 9th, Martinsburg reported 144 beds could be made available to DoD on 24 hours notice. We found that on that date the center had a total of 120 beds staffed and supported. The hospital reported to our on-site team on January 11th that a total of 31 beds could be made available within 24 hours.

  - - West Los Angeles: On January 9th, Martinsburg reported 809 beds could be made available to DoD on 72 hours notice, a number that had been consistently reported by Martinsburg for the center's annual plan. On the day of our visit, the center had a total of 926 staffed and supported beds and center personnel had identified a total of 302 beds that could be made available to DoD on 72 hours notice.

- - Hines: On January 9th, Martinsburg reported that 591 beds could be made available to DoD on 72 hours notice out of 1,097 total beds that were staffed and supported. On the day of our visit we found that there were only 809 beds actually staffed and supported. The center's estimate of 72 hour bed availability (the number synonymous with the annual planned figures for bed availability) were variously reported by the center to Martinsburg as 591 (8/30/90), 439 (1/4/91), and 336 (1/14/91).

- We noted other inconsistencies in data reported for bed availability. For example, at Wilmington, DE 26 beds were reported to be available on 24 hours notice on January 9th. The 72 hour availability estimate for the same date showed that only 21 beds would be available. Our on-site review team noted that the 21 beds were actually additional beds that could be made available on 72 hours notice. We found similar misreporting at nine other medical centers, where local officials had misinterpreted the intent of the 72 hour bed availability figure; i.e. they had not considered the 72 hour availability number to be cumulative, which would include the number they had reported that could be available in 24 hours.

- VHS&RA's new reporting system, now being tested, may correct the causes of some of the errors detected during our review. Manual specifications for the new system show that it: (i) allows direct input by each medical center, (ii) has edit features for data validation by facility type and by VHS&RA regional offices, and (iii) contains certain automated edits and summary reports by program objective. VHS&RA officials provided us with a copy of the automated report from the new system on January 18, 1991. We compared 24 and 72 hour bed availability data in the VA Bed Availability Report for January 17th, for the medical centers cited in this information paper, to the data reported on January 9th. Our review of the document indicates that the data for these sites has apparently been reported to more accurately reflect the bed availability of the medical centers.

- Based on the results of our reviews at some of the medical centers we visited and data reported to DoD by the Emergency Facilities Operations site at Martinsburg, WV, we believe the current mechanism for reporting bed availability to DoD is not reliable, in terms of the number and categories of beds at individual medical centers.

- Our overall conclusion for the Committee's first concern is that VHS&RA has the capacity to meet its goal of 25 percent bed availablity within 72 hours. However, we found significant reporting problems at four medical centers and less serious problems at ten others. The Agency's ability to tell DoD where vacant beds are located is affected by these individual medical center reporting problems. The Agency has corrective action in process; however, it was not yet functioning as of January 16, 1991.

o Concern 2. **Whether VA staff who would be responsible for coordinating the transportation of VA patients and incoming active-duty service personnel at individual VA facilities have been specifically designated and trained.**

- At the VA medical centers reviewed, 17 were primary centers that relied on Federal Coordinating Centers to provide initial transportation of military casualties to their medical center. As primary medical facilities with the possibility of having to move VA patients to secondary VA medical centers, most facilities have made the necessary contacts with local ambulance services to determine their availability to transport VA patients to a secondary VA medical facility. Four VA Medical Centers (Atlanta, Birmingham, New Orleans and San Antonio) also act as Federal Coordinating Centers and have the responsibility to provide reception at the air field and to arrange to transport casualties to military or VA medical facilities. Based on our review of the contingency plans for these sites and discussions with center personnel, we found they were aware of their roles and have taken the necessary actions to meet the contingency.

o Concern 3. **Whether VA staff who would be responsible for coordinating communication, among VA facilities and community based referral facilities at individual VA facilities have been specifically designated and trained.**

- **Most VA Medical Centers we visited reported that staff who would be responsible for coordinating communication had been designated and trained; generally, an emergency coordinator was designated, although communications coordinators were not always cited. Some medical centers completed the self-assessment guide in Circular 10-88-116 but others had not. However, most medical centers reported significant coordination activities involving conferences, meetings, training activities and/or drills to prepare for contingencies.**

- o **Concern 4.** **Whether the numbers, specialties, and subspecialties of personnel who are reservists and have been or are subject to being called to active duty are adequately identified and accounted for by medical centers. For example, do medical centers simply report registered nurses subject to call or do they also provide information such as the number of nurses who are critical care nurses, rehabilitation nurses, spinal cord injury nurses, etc.?**

- Each VA medical center is tracking military reservists who have volunteered, been mobilized or alerted by name, title, service and category . With this information, each medical facility is able to monitor the impact on the center's ability to provide medical care. Some centers that have lost critical medical personnel are reflecting this information in their bed counts that are reported available for DoD casualties. However, facility personnel in general agree that the numbers of reservists being called up or alerted have not had a significant impact on patient care at this time.

- o **Concern 5.** **Do medical center plans adequately provide for the evaluation of patients currently hospitalized to assess the need to continue their hospitalization in the community or permit discharge from care? Also, has the medical center made contingency plans for acceptance by community facilities of those patients who may be displaced due to incoming casualties and for appropriate modes of transportation for those patients?**

- VA medical facility contingency plans generally provide for the evaluation of patients currently hospitalized. These plans range from formal assessments with designated forms to reviews by Chief Nurses and Chiefs of Social Work Service. Our review identified seven facilities with planning deficiencies in this area. Their plans did not specify all the steps necessary to identify patients for discharge or transfer: two facilities did not identify an outplacement source, four did not identify transportation mechanisms to secondary or community resources, and one facility was deficient in all three areas.

o Concern 6. **Where specialized medical programs exist, such as Spinal Cord Injury Centers, has the medical center adequately taken into account the scarcity of resources for this type of care in the community and adjusted their bed-availability figures to reflect that information and the need to continue to provide care to the current patient population?**

- Because of the Committee's specific interest, we focused on spinal cord injury (SCI) units and extended our inquiry to determine whether the bed availability data reported was reasonable in terms of community or other support. Generally, the medical centers reviewed have assured continuity of care to the current SCI patient population. Our review identified three medical centers that had considered the availability of community resources in their estimates and one center that did not. VAMC Milwaukee planned to accept 14 active duty personnel when they had 40 patients in the SCI unit, which was 2 more than they considered a fully staffed and supported unit could support on the day of our visit. In addition, we identified one medical center that does not have a spinal cord injury unit, but has identified ten beds in the community that could be used for preliminary patient treatment and patient transfer to area medical centers that have specialized care facilities. The operating beds and 72 hour bed availability data reported by these medical centers is as follows:

VAMC	SCI BEDS	REPORTED TO DoD
AUGUSTA	60	15
HINES	175	48
MILWAUKEE	48*	14
RICHMOND	120	38
PHILADELPHIA	0	10

CONGRESSMAN MONTGOMERY

Question: 12. Given that the VA has treated only a small fraction of the 479,000 Vietnam veterans believed to be suffering from PTSD and that the current capacity in the VA to treat these veterans is stretched precariously thin, how will the Department be able to care for more such veterans resulting from any hostilities in the Middle East?

Answer: VA's Mental Health and Behavioral Sciences Service and Readjustment Counseling Service have been preparing for the possibility of having to address the mental health needs of casualties from Middle East hostilities in a variety of ways. Educational programs are being carried out to prepare VA mental health clinicians to manage acute traumatic stress reactions, both in those identified as psychiatric casualties and in those men and women with physical injuries. The VA/DoD Contingency Plan allows for shifting of certain resources to cope with the crisis. One example of this is the authorization to use Vet Center clinicians and counselors in support of VA medical center traumatic stress treatment activities. It is possible that some VA medical centers will face a challenge in coping with a new influx of traumatic stress patients, because of existing vacancies in psychiatrists and other clinicians, loss of clinicians to active duty, and because a significant proportion of the current inpatient psychiatry workload consists of service-connected veterans with serious degrees of illness. The mechanisms of the Contingency Plan should allow VA, overall, to cope effectively with Middle East casualties suffering from traumatic stress disorders.

U.S. Department of Labor

Assistant Secretary for
Veterans' Employment and Training
Washington, D.C. 20210

APR 1 0 1991

The Honorable G. V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

As requested, enclosed are our responses to the questions raised following our budget hearing on February 20. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Thomas E. Collins

THOMAS E. COLLINS

Enclosures

Budget Hearing - February 20, 1991
Questions from Congressman Timothy J. Penny

Question 1. First, I'd like to discuss the President's request for DVOP funding. As you know, the House passed last year, and earlier this year, legislation which would extend the sunset provisions affecting DVOP staffing. We expect the other body to take up and approve that legislation some time this week.

A. In the event that Desert Storm results in significant casualties, how would the President provide employment services and do outreach to returning disabled and other servicemembers in the absence of a strong DVOP program? I've been told there is some kind of "contingency" plan, but it has yet to be described.

Response:

We of course are thankful for the quick success of Operation Desert Storm and think that we will be able to handle veterans' employment and training needs resulting from the war using existing programs and resources coupled with a strong public information campaign, because the brunt of the post-Desert Storm impact will occur in calendar year 1991. Of course employment and training services by the DVOP staff, including outreach, will continue to be available to disabled and other veterans through the various State Job Service local offices on a priority basis as it has always been. Our comprehensive public information campaign, already underway, is directed to the returning servicemembers, Reservists and Guardmembers, and to employers to explain reemployment rights and obligations, employment and training services available, and where to go for assistance.

b. What level of DVOP staffing does the $34.9 million requested by the President support during the first quarter of fiscal year 1992? I'm told this would fund only 1,478 positions, 438 below the mandated level of 1,885. If that is correct, how did this happen? Did the President deliberately underfund this program for disabled and other veterans?

Response:

During the first quarter of FY 1992, approximately 1,792 DVOP positions could be supported by the $34,910,000 requested. The funding request was based on the DVOP appropriation for FY 1991. The 1991 average cost per position plus a 4.4 percent inflation factor was applied to the number of DVOP positions funded in FY 1991 to estimate the costs for the pre-sunset first quarter of FY 1992. For the remaining three quarters, all 438 post-sunset DVOP positions were funded, again at the 1991 average cost per position plus 4.4 percent inflation.

The Department plans to avoid the necessity for the reduction-in-force administrative and pay costs, to the extent possible, through the absorption of affected individuals into State agency positions funded under other sources.

c. What funding level would be necessary in order to ensure that DVOPs would be fully staffed according to the Congressionally-mandated level if the sunset provision were amended?

Response:

To fund 1,885 DVOP positions would require an additional $51,752,000 above the $34,910,000 in the budget request, a total of $86,662,000.

Question 2. On page 2 of your statement you note that the President's budget would support 1,492 LVER (local veterans' employment representatives) positions. As I'm sure you know, section 2004(a)(1) of title 38, United States code, clearly states that funding for a minimum of 1,600 LVERs is to be made available to the States.

Again, I am perplexed that the President would deliberately underfund a veterans' employment program, ignoring the clearly mandated statutory staffing level. What additional funding would be necessary in order to fully fund that mandated level? How was the figure of 1,492 determined?

Response:

To fund the LVER positions at the 1,600 level would require approximately $6,000,000 added to the $74,223,000 in the FY 1992 budget request, a total of $80,032,000.

The 1,492 figure is an estimate based upon the FY 1991 appropriation of $71,095,000 for the program and the estimated cost of LVER positions for FY 1992. The FY 1991 amount of the appropriation was inflated by 4.4%, resulting in the budget request of $74,223,000. The $74,223,000 requested was divided by the estimated average cost per position of $49,750 to derive the estimate of 1,492 LVER positions which could be supported by the budget request.

Question 3. I understand the Homeless Veteran Reintegration Project (HVRP) has been a great success. Unfortunately, I note there is no McKinney Act money in your budget to continue this project. How will this money be allocated in FY 1992?

Is there any way you can ensure that HVRP money is made available through the agency designated to administer McKinney Act funds?

Response:

The Administration has decided to consolidate McKinney Act homeless responsibility and funding into a smaller number of innovative demonstration programs to develop comprehensive service strategies that hold promise of helping people to leave homelessness. Administered by the Department of Housing and Urban Development, the program would provide grants to homeless service providers, States, or local governments to meet the longer term needs of the homeless. It would provide a single source of funds for projects encompassing a variety of needs, including job training and placement assistance. The Department of Labor would participate in a Federal panel which would review grant applications under a competitive process. Where appropriate, we would furnish information and advice regarding our experience in administering HVRP to make decisions on the grant applications.

Question 4. A provision of Public Law 101-510, the National Defense Authorization Act for Fiscal Year 1991, authorized $9 million for the Department of Labor for the Transition Assistance Program (TAP). Under this program, separating servicemembers are provided employment assistance in order to smooth their return to civilian life.

First, would you clarify the amount requested for this program in the Administration's budget? One DOL document says $1.8 million while another says $2.05 million.

In your statement, you mention that TAP workshops will be staffed by contract facilitators. How many such facilitators do you expect to be able to provide with the funding level in the budget? What percentage of TAP workshops do you expect to be staffed by contract? What percentage do you expect to be staffed by LVERs?

With the near termination of the DVOP program on January 1, 1992, how can any LVERs be made available to do TAP training? It was made very clear in PL 101-510 that LVERs and DVOPs are not to be used for TAP if their absence from their local office adversely affects services to other veterans. I don't believe that can be avoided, particularly if DVOPs are reduced by 70 to 80%.

You mention in your statement that training of TAP workshop faculty will be a responsibility of VETS. How and where do you intend to carry out that training? Will you use NVTI facilities between now and October 1st?

You also mention that a program evaluation of TAP is scheduled for completion in May 1992. How is that evaluation being conducted? What criteria is being used to determine the effectiveness of the program? Have you contracted for that evaluation? Would a VETS self-evaluation have limited value?

We can expect that at the end of Desert Storm, an extraordinary number of individuals will be separating from military service. The 200,000+ members of the Guard and Reserve who have been called up will be returning to the civilian employment sector, and some of them will find their pre-service employment unavailable because of the recession. Others will find they want to pursue employment opportunities other than those they left before being activated. Additionally, the military's stop-loss policy will be lifted, and many thousands of individuals whose separations were postponed will be leaving the Armed Forces. Additionally, the military personnel drawdown is apparently going to continue -- somewhat delayed, but nonetheless continued. Additionally, the 200,000 individuals who normally leave the active duty military during any year will be separating. Do you believe the $2 million in the budget for TAP is adequate to enable you to serve all the individuals who should be, and want to be, assisted in their efforts to obtain civilian employment? What amount would enable you to implement this program as intended by Congress?

Response:

The budget for TAP in FY 1992 is $2.05 million, an increase of $1.8 million over the FY 1991 budget of $225,000 for TAP.

All of our planning for the 1992 TAP budget request was based on the assumptions that 800 workshops among TAP sites in 36 States will suffice to serve 60,000 separatees, and that demand will not exceed the 60,000 participants level.

Our workshop delivery plans provide for use of facilitators from three sources: State Employment Service agencies personnel, Department of Defense civilian employees, and contractors. We expect in some areas that the State ES will offer the use of personnel other than LVERs or DVOP staff; however, in the absence of firm numbers of ES staff projected to be stationed in local offices in close proximity to projected sites, we cannot say with certainty what percentage of workshops will be staffed by LVERs, or by contractors. With so many variables involved, we cannot say with certainty how many facilitators we must hire.

Although we think that linkage to the State ES is vitally important to the success of the early intervention strategy behind TAP, we have reserved in the TAP budget $800,000 for contract facilitators. Those funds would be used to contract for facilitators for sites where the available local resources are insufficient.

I believe that LVERs may be used for TAP workshops, within the guidance provided by P.L. 101-510, in many locales. However, in any locale where involvement in TAP by LVERs clearly would significantly interfere with the ability of the local ES office to provide mandatory services, we will use contract personnel as facilitators. Our experience thus far has been that TAP does not negatively impact on affected offices' overall services to veterans.

Training of 120 TAP workshop facilitators will be accomplished in FY 1991 at the NVTI. The curriculum and training materials will become VETS' property when the NVTI ceases operations. The $2.05 million budget for TAP in 1992 includes funds for training of additional workshop facilitators, but we have not yet decided on the service provider for delivery of the training.

The evaluation plan required by P.L. 101-237 will be an analysis of post-separation employment outcomes of demographically comparable groups consisting of those having attended TAP and those who did not. Four areas will be evaluated: Labor Force Behavior, Income, Satisfaction with Separation Services, and the use of UCX and Regular Unemployment Compensation Benefits. As we believe any internal evaluation of TAP might appear to be self-serving, we plan to contract out the actual evaluation.

Due to the success of Operation Desert Storm, the release of the reserves and Guard members called to duty will predominantly occur in FY 1991. Further, as the demobilization of servicemembers held in service due to the war will be expedited, much of the initial downsizing impact will be in FY 1991, not 1992. They will be allowed to attend TAP at a military installation near their home if one is available. We are attempting to activate TAP sites at installations which provided significant numbers to Desert Storm; e.g., Camp LeJeune, in order to serve those servicemembers separating when the stop-loss is lifted; however, this must be done with the FY 1991 appropriation. We believe the $2.05 million level of funding will allow us to implement the program as required by the Congress, based on the assumptions stated in our appropriation request.

Question 5. I understand that travel funds for Directors and Assistant Directors for Veterans Employment and Training is being significantly reduced. This will result in an imbalance between the work requirements for these individuals and their ability to meet their responsibilities because of inability to travel. I've been told that in at least one state, they are limited to hotels costing $40/night. Any cost above that might come out of their pockets.

I'd appreciate your explanation of this situation. Please also provide me, for the record, a breakdown by state and central office of travel funds available for the remainder of FY 1991 and 1992.

Response:

We believe that we have taken a very responsible approach to ensuring that the VETS field staff have the funds available to accomplish the agency's mission this year. We do require travelers, whether they be field or central office staff, to be prudent. As far as lodging expense limitations are concerned, VETS staff are limited by the maximum rates prescribed under part 301-7.3 of 41 CFR, Chapter 301, applicable to all Government agencies. In many areas of the country the maximum daily rate for lodging is less than $45.00. VETS management does not impose the restrictions you referred to in your question.

It is not true that travel funds for VETS field staff have been, or will be, reduced. The initial allocation to the field for FY 1991 exceeded the amount spent by the field staff in FY 1990 by $17,000. The amount of travel funds initially allocated was certainly sufficient for VETS field staff to accomplish their basic grants monitoring and Job Service local office evaluation requirements, as well as their normal level of VRR case activity. Furthermore, we have a contingency plan for increasing the allocations, based on real needs related to Veterans' Reemployment Rights (VRR) program activities resulting from the return of military personnel from Operation Desert Storm. VETS is planning to provide briefings at every demobilization site to ensure that everyone who was called to duty has the opportunity to learn about their reemployment rights, and who to contact should they encounter problems. VETS also has contingency plans for allocation of more travel funds to cover temporary duty assignments, should there be a disproportionate number of VRR cases in certain geographic areas. Should VRR activities require more travel than expected, $50,000 from personnel compensation funds (less than one-half percent of VETS 1991 personnel compensation budget) which we anticipate may be available due to turnover, would be transferred into the travel object class.

While the following breakdown of VETS travel budget is only approximate due to the aforementioned contingencies, the figures do represent VETS' commitment to support of field staff activities:

	Amounts in thousands		
	Total	Field Offices	Central Office
FY 1991 (Initial)	$505	$353	$152
FY 1991 (With contingency)	$555	$430	$125
FY 1992 (Initial)	$522	$370	$152

Questions Submitted by Congressman Chris Smith

Question 1. As you are aware, legislation passed by the House and soon to be acted on by the Senate, HR 180, will extend the definition of a Vietnam Era veteran as related to DVOP staffing levels. Are you prepared to fund these positions? Do you have figures developed?

Response:

Funding of the additional DVOP positions following the extension of the Vietnam-era veteran definition is dependent upon Congressional appropriations.

To fund 1,885 DVOP positions for FY 1992 would require an additional $51,752,000 in funding above the $34,910,000 in the budget request, a total of $86,662,000.

Question 2. You proposed in your FY 1992 budget request the elimination of the National Veterans' Training Institute. How do you intend to provide training for new employees or update the skills of employees who may need additional training relating to the needs of Operation Desert Storm veterans?

Response:

We do not foresee that Operation Desert Storm will create additional training needs for either State Job Service agency employees (i.e., DVOP and LVER staff) or for VETS staff. The veterans of Operation Desert Storm will not pose significantly different challenges to those who must provide services to them. We believe that in the short term, the DVOP, LVER and VETS staff currently on board have been, or will be by the end of FY 1991, adequately trained to serve the veterans of Operation Desert Storm. To meet training needs of new employees that might arise in calendar year 1992, VETS most likely would use the instructional materials developed by the Department of Labor and NVTI, and would offer the same to the State agencies, as the basis for in-house training delivered by agency employees.

Question 3. You state in your testimony that you plan to maintain current staffing levels for Veterans Reemployment Rights (VRR) and intend on establishing as a top priority services to Operation Desert Storm veterans. Without an increase in staffing levels, how will these added demands be met without affecting services to other veterans?

Response:

We anticipate that the major events that will follow Operation Desert Storm that will affect the VETS and its State agency partners will be the return of reservists and Guard members to their civilian employers in 1991, and an increase in the numbers of persons separated from the military services and re-entering the civilian world. The former could produce an increase in the number of reemployment rights cases. VETS plans to try to prevent a large increase by implementing in 1991 a national public information effort intended to educate employers as well as individuals as to their obligations and entitlements. VETS also will increase its productivity in the VRR program by training more staff to handle VRR cases. By taking those initiatives we believe we can meet the needs of those veterans of Operation Desert Storm without a significant impact on other veterans.

Question 4. What are you doing to ensure that the Homeless Veterans' Reintegration Program is adequately funded and implemented under the Department of Housing and Urban Development?

Response:

The Administration has decided to consolidate McKinney Act homeless responsibility and funding into a smaller number of innovative demonstration programs to develop comprehensive service strategies that hold promise of helping people to leave homelessness. Administered by the Department of Housing and Urban Development, the program would provide grants to homeless service providers, States, or local governments to meet the longer term needs of the homeless. It would provide a single source of funds for projects encompassing a variety of needs, including job training and placement assistance. The Department of Labor would participate in a Federal panel which would review grant applications under a competitive process. Where appropriate, we would furnish information and advice regarding our experience in administering HVRP to make decisions on the grant applications.

Question 5. You state in your testimony that at the requested funding level of $8,792,000 for your share of the JTPA, 5,099 eligible veterans will be served. Is this the total pool of eligible veterans?

Response:

The number of eligible veterans to be served under JTPA, Title IV, Part C, is based on the amount of available funds, not on the number of eligible veterans. According to JTPA, Title IV, Part C, the target groups of veterans to be served are disabled veterans, Vietnam-era veterans, and recently separated veterans. Since an individual veteran can be identified as a member of any one or some combination of the three target groups, it is not possible to estimate the total number of eligible veterans.

United States
Court of Veterans Appeals

Chambers of
Chief Judge Frank Q. Nebeker

625 Indiana Avenue, N.W., Suite 900
Washington, D.C. 20004
202-501-5862

March 14, 1991

Honorable G. V. (Sonny) Montgomery
Chairman
U.S. House of Representatives
Committee on Veterans' Affairs
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed in the format you requested is my response to the single question attached to your letter to me of February 25, 1991.

Sincerely,

Frank Q. Nebeker

Frank Q. Nebeker
Chief Judge

Enclosure

QUESTION SUBMITTED BY HONORABLE BOB STUMP
TO THE COURT OF VETERANS APPEALS
AT THE FULL COMMITTEE HEARING
FEBRUARY 20, 1991
VA BUDGET
TO
CHIEF JUDGE FRANK Q. NEBEKER
U.S. COURT OF VETERANS APPEALS

QUESTION:

What suggestions would you recommend to alleviate the problems the Court is having with unrepresented appellants? In this connection, please elaborate on the potential conflict of interest which was mentioned by Judge Kramer in our hearing on the Court's budget on February 20, 1991.

ANSWER:

With respect to your request to elaborate on Judge Kramer's mention of a potential interest conflict, I see, the problem as one of the Court's role in review of pro se appeals. In a similar vein to his statement, I observe that an unrepresented veteran before the Court is awash in an unfamiliar and adversary process where the Secretary is represented by counsel specialized in veterans' appeals. This is not unlike the situation in federal and state Courts where one party is represented by counsel and the other is "going it alone". I have extensive experience with those cases during my nearly 30 years in the United States Attorney's Office and on the District of Columbia Court of Appeals and well know the extra burden that falls on the litigant and the Court. When this Court undertakes a review of an appeal by a pro se veteran we, of necessity, assume the role of counsel to the extent that we must first try to identify--in proper legal context--the issues poorly articulated by the pro se veteran. Since the veteran is disadvantaged by an inability to identify issues we feel that interests of fairness also suggest that it is necessary for the Court to comb the record to see if other issues are available to be raised which would be obvious to a trained advocate.

I believe this is what you are referring to by a conflict of interest. The problem is not actually one of an interest conflict, but one in which the Court may lose or appear to lose its neutrality in the quest to do justice and maintain evenhandedness in the appellate process. This problem is particularly significant to us since we have a far higher percentage and number of pro se cases than any other Court.

While it is more difficult to review and decide a case where the veteran is unrepresented--a point discussed below--the real problem is one experienced by the pro se veterans themselves. Our efforts are aimed more at helping them present their cases to the Court, though, to be sure, the Court can review and decide more cases in less time if they are presented in a professional way. Though some tentative solutions do spring to mind, I am reluctant to burden you with them at this early time. My hesitance is due to the fact that the Court has appointed an Advisory Committee on Representation. That Committee will report to the Court this summer.

The Court's charge to the Committee includes exploring effective ways, if any, to enlist the organized bars and bar associations nationwide to offer appellate Court representation to veterans, and to persuade veterans service organizations to expand or begin programs of veteran representation before the Court. The feasibility of these ideas and perhaps others should be thoroughly explored before a publicly funded solution is considered.

I am glad we share a concern and interest in solving this problem. I will report to you in the next few months on the Advisory Committee's action and the Court's proposal to provide our veterans' with representation before this Court.

Thank you again for your interest in solving this problem. I will share with you the report of our Committee and the Court's reaction to it just as soon as possible.

STATEMENT OF
REP. JIM JONTZ

before the

HOUSE COMMITTEE ON VETERANS' AFFAIRS

Hearing on the Fiscal Year 1992
Department of Veterans Affairs Budget

FEBRUARY 21, 1991

Mr. Chairman, I appreciate the courtesy which you are extending to me today in permitting me to testify on the VA's budget for Fiscal Year 1992.

Before I address the budget, I just wanted to take a moment to thank you, the ranking member Mr. Stump, and the committee staff for all the assistance that you provided to me during my tenure on this committee. It was an honor to have served under your leadership on the committee in both the 100th and 101st Congresses. I remain proud of the many accomplishments of the committee and look forward to working with you in the coming months to address the tremendous challenges which still face the VA.

Mr. Chairman and members of the committee, I am pleased that the administration has proposed an increase in the VA's medical care budget, but I also share your view that this proposed $976 million increase will be consumed by inflation and the pay reform legislation and is far from adequate.

As the chairman has frequently pointed out, the VA medical care budget has not kept pace with funding for other health care services provided by the federal government, such as Medicare and Medicaid.

Compounding the problem this year is the likelihood that thousands of new Persian Gulf veterans will require medical care from the VA when they return from the Middle East. The administration's budget proposal does not address this need nor does it adequately assist the VA to keep pace with current demands.

I was greatly disappointed yesterday to hear Budget Director Richard Darman's statement that benefits which would be established for veterans of the Persian Gulf war would have to come from within the existing cap on domestic expenditures.

Mr. Chairman, I know that you and the committee believe very strongly that it is our obligation to care for these future veterans. Persian Gulf veterans should not have to compete with other domestic needs. Benefits for these veterans should be viewed as direct costs of Operation Desert Storm, just as much as Patriot missiles are.

Caring for our troops when they return from the Persian Gulf is as great an obligation as supporting them while they are on the battlefield.

Mr. Chairman, there is no greater example of this funding dilemma than the Administration's budget proposal for post-traumatic stress disorder treatment programs and the VA's Readjustment Counseling Service.

My concern about PTSD funding today is basically the same as it was one year ago at these same proceedings: to ensure that more of the 400,000-plus Vietnam veterans -- and veterans from other conflicts who are still suffering from PTSD but who haven't been served by the VA -- are afforded treatment for their combat-related condition.

The focus today, however, is changed by the war in the Persian Gulf. The prospect of thousands of veterans returning home who may require mental health services, including readjustment counseling and PTSD treatment, but who won't be able to receive them because the system is already strapped, must be of deep concern to the committee.

The FY 1992 budget proposal contains no proposed increases for PTSD treatment or readjustment counseling programs beyond inflation. The budget calls for $20.265 million to maintain the current 20 inpatient units, 44 PTSD clinical teams, as well as the operations of the National Center on PTSD. This is an increase of $965,000, or 4.8 percent.

The Readjustment Counseling Service Vet Center budget calls for $52.124 million to maintain the 195 Vet Centers. This is an increase of $2.342 million, or 4.5 percent.

As you know, Mr. Chairman, in the last Congress I was the author of H.R. 3037, legislation to expand the VA's programs for PTSD treatment and readjustment counseling. It was modified and passed as part of H.R. 5740, the Veterans' Health Care Amendments of 1990, on October 15th. Unfortunately, the Senate did not consider the bill before adjournment.

This year I have reintroduced the legislation, with appropriate changes to accommodate the needs of veterans of the Persian Gulf war. H.R. 841, the Veterans PTSD Treatment and Psychological Readjustment Act of 1991, would add 30 new inpatient units and 50 new PTSD clinical teams over the next four years, which would implement the recommendations of the Chief Medical Director's Special Committee on PTSD. The bill would also add 40 new Vet Centers, a halfway house program, and would ensure that Persian Gulf veterans and their families have access to the VA's readjustment counseling programs.

I would note, Mr. Chairman, that this is the seventh year that the VA has ignored the Special Committee's recommendations for expanding the PTSD program. It is especially disappointing given the increased incidence of Vietnam veterans seeking help for PTSD with the onset of hostilities last month.

Now is the time to expand these services, in order to avoid another period of costly delays in providing help to veterans with PTSD treatment needs.

I commend the authors of the Independent Budget for FY 1992 for their request for increased PTSD treatment funding. The Independent Budget recommends $7.25 million in additional funding to add 20 new PTSD clinical teams and 4 new inpatient units.

For Fiscal Year 1992, I would propose that the committee consider a funding increase of $12.5 million for PTSD treatment and readjustment counseling, at a minimum.

H.R. 841 proposes at least 15 new PTSD clinical teams, 5 new inpatient units, 5 new Vet Centers, and a halfway house program to begin in FY 1992. I have requested a CBO cost estimate on the legislation, and will forward this information to the committee as soon as I receive it.

Mr. Chairman, it is vital that we expand the VA's PTSD treatment and readjustment counseling programs before thousands more veterans place an even greater demand on the system.

The VA is clearly the world leader in treating PTSD, but not enough resources have been devoted to this purpose. I would urge the committee to consider an appropriate funding increase in its recommendations to the Budget Committee.

Mr. Chairman, before I conclude, I would like to draw the committee's attention to the construction budget. The Administration's proposal includes $45.8 million for the construction of a new 240-bed geropsychiatric facility at the Marion, Indiana, VA Medical Center. I fully support this funding request, and would urge the committee to adopt it, as well.

As you may remember, the committee recommended $4.3 million for the design of this project for FY 1990 which was signed into law. The design phase has been completed, and the approval of these funds would ensure the timely completion of this project, which has had the support of the Administration, this committee and the Congress in the past.

The new geropsychiatric wing is much needed and would replace several 19th century-era buildings which do not have elevators, central air conditioning and handicapped accessibility. The new wing would allow Marion to continue to delivery quality mental health and acute medical services. Design of the new facility was completed in July of last year, and under the administration's proposal, construction would be completed by the end of 1994.

I know that the committee will do much good work on behalf of veterans in this Congress, and that a significant amount of important legislation has been approved already. I look forward to assisting the committee in any way possible.

Thank you.

STATEMENT OF REPRESENTATIVE BENJAMIN A. GILMAN REGARDING OUR NATION'S VETERANS FUNERAL BENEFITS

FEBRUARY 21, 1991

THANK YOU FOR THE OPPORTUNITY TO TESTIFY BEFORE THE HOUSE COMMITTEE ON VETERANS AFFAIRS TODAY REGARDING THE NEED TO BOOST VETERANS FUNERAL BENEFITS (H.R. 103). I WOULD ALSO LIKE TO THANK CHAIRMAN MONTGOMERY AND THE RANKING MINORITY MEMBER, MR. STUMP FOR CONDUCTING A HEARING ON THIS IMPORTANT ISSUE.

ON JANUARY 3, 1991, I INTRODUCED H.R. 103, LEGISLATION TO BOOST FUNERAL BENEFITS TO A LEVEL PREVIOUSLY AFFORDED TO ALL OUR WARTIME VETERANS.

PRIOR TO 1981, A BURIAL ALLOWANCE OF UP TO $300 WAS PROVIDED IN ALL CASES WHERE A VETERAN DIED: FIRST, OF SERVICE-CONNECTED DISABILITY; SECOND, IF HE WAS A VETERAN OF ANY WAR; THIRD, IF HE WAS DISCHARGED FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY; OR FOURTH, IF HE WAS IN RECEIPT OF, OR ENTITLED TO, DISABILITY COMPENSATION.

UNDER THE OMNIBUS RECONCILIATION ACT OF 1981, THE VETERANS' BURIAL BENEFITS WERE DECREASED SIGNIFICANTLY BY LIMITING FUNERAL BENEFITS TO VETERANS RECEIVING PENSION OR COMPENSATION BENEFITS, OR RESIDING IN A VA SUPPORTED HEALTH FACILITY AT THE TIME OF DEATH. THAT REDUCTION MISTAKENLY PLACED AN ECONOMIC VALUE ON A BENEFIT GIVEN BY CONGRESS TO ENSURE THAT ALL VETERANS WOULD BE BURIED WITH DIGNITY AND RESPECT, REGARDLESS OF THEIR INCOME OR SOCIAL STANDING AT TIME OF DEATH. IT IS ALSO IN DIRECT VIOLATION OF A LONGSTANDING PRINCIPLE HELD BY THE AMERICAN LEGION WHICH CALLS FOR EQUAL BENEFITS FOR EQUAL SERVICE.

THE 1990 OMNIBUS RECONCILIATION ACT FURTHER LIMITED BURIAL PLOT ALLOWANCES. THE 1990 VETERANS BENEFITS AND SERVICES RECONCILIATION CONFERENCE AGREEMENT ELIMINATES THE PLOT ALLOWANCE OF $150 WITH THE EXCEPTION OF VETERANS WHO ARE IN RECEIPT OF DVA DISABILITY BENEFITS, SUCH AS COMPENSATION OR PENSION.

MY LEGISLATION RESTORES THE PRE-1981 ELIGIBILITY FOR VETERANS FOR THE PURPOSES OF RECEIVING FUNERAL BENEFITS, INCREASES THE AMOUNT OF THOSE BENEFITS FROM $300 TO $400, AND INCREASES THE PLOT ALLOWANCE FROM $150 TO $300.

MR. CHAIRMAN, THE DEATH OF A LOVED ONE IS AN EMOTIONAL STRAIN ON A FAMILY, IT SHOULD NOT BE A FINANCIAL ONE TOO. IN THESE TIMES, THE COST OF A BURIAL HAS INCREASED DRAMATICALLY, OFTEN BECOMING A TREMENDOUS FINANCIAL BURDEN OF THE FAMILIES OF THESE VETERANS DURING THEIR TIME OF GRIEF. IT IS MY SINCERE HOPE THAT MY LEGISLATION WILL HELP DEFRAY A PORTION OF THESE BURDENSOME COSTS.

AS THE FIGHTING IN THE PERSIAN GULF CONTINUES TO ESCALATE, WE MUST REALISTICALLY EXPECT THE NUMBER OF CASUALTIES TO RISE. NO ONE LIKES TO THINK ABOUT THE POSSIBILITY OF DEATH. OUR SERVICEMEMBERS AND THEIR FAMILIES HAVE ENOUGH TO WORRY ABOUT. THEY SHOULDN'T HAVE TO WORRY ABOUT PAYING FOR A FUNERAL AS WELL.

WE HAVE A MORAL OBLIGATION TO RESTORE THESE BENEFITS THAT WE PROMISED TO OUR NATION'S VETERANS AT THE TIME OF THEIR INDUCTION INTO THE SERVICE OF THEIR COUNTRY, TO PROVIDE THEM WITH REASONABLE COMPENSATION FOR THEIR FUNERAL COSTS. REINSTATING THESE DESERVED BENEFITS TO OUR VETERANS IS ESSENTIAL TO FULFILL OUR OBLIGATION TO ALL THOSE WHO HAVE FOUGHT AND RISKED THEIR LIVES TO PROTECT THE IDEALS AND PEOPLE OF OUR GREAT NATION.

PERMIT ME ONCE AGAIN, CHAIRMAN MONTGOMERY, TO EXPRESS MY APPRECIATION TO YOUR COMMITTEE FOR THE OPPORTUNITY TO TESTIFY BEFORE YOU TODAY.

FEBRUARY 2[illegible], 1991
COMMITTEE ON VETERANS' AFFAIRS
HEARING ON 1992 DVA BUDGET
OPENING REMARKS, HONORABLE DAN BURTON

GOOD MORNING, MR. CHAIRMAN. WE MEET TODAY TO HEAR TESTIMONY ON THE ADMINISTRATION'S PROPOSED 1992 BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS (DVA) FROM OUR NATION'S VETERANS' SERVICE ORGANIZATIONS. OUR REVIEW OF THIS YEAR'S BUDGET COMES AT A CRITICAL TIME FOR OUR COUNTRY. OVER 500,000 UNITED STATES' MILITARY PERSONNEL ARE NOW RISKING THEIR LIVES TO FREE KUWAIT AND BRING PEACE AND STABILITY TO THE GULF REGION. IT IS INCUMBENT UPON THIS COMMITTEE TO ENSURE THAT THESE FUTURE VETERANS, AS WELL AS ALL VETERANS WHO HAVE ALREADY SACRIFICED FOR THIS COUNTRY'S FREEDOM, HAVE ACCESS TO QUALITY V.A. HEALTH CARE.

AFTER EXAMINING THE PRESIDENT'S 1992 BUDGET, I BELIEVE THERE IS REASON FOR

OPTIMISM WITHIN THE DEPARTMENT OF VETERANS AFFAIRS. THIS YEAR'S BUDGET FOR FEDERAL VETERANS' PROGRAMS IS THE LARGEST EVER PROPOSED, AND INCLUDES A RECORD LEVEL OF FUNDING FOR VETERANS MEDICAL CARE. SPECIFICALLY, IT REQUESTS $33.2 BILLION IN BUDGET AUTHORITY, AND IT CONTAINS CLOSE TO $1 BILLION INCREASE IN THE V.A. HEALTH-CARE BUDGET.

THE HEALTH-CARE REQUEST, WHICH TOTALS $13.3 BILLION, INCLUDES FUNDING INCREASES FOR AGING VETERANS PROGRAMS, DRUG ABUSE TREATMENT, PATIENT ENVIRONMENT IMPROVEMENTS, AND MEDICAL SHARING AGREEMENTS WITH THE DEPARTMENT OF DEFENSE.

A FREQUENT COMPLAINT THAT I HEAR FROM MANY OF OUR NATION'S VETERANS' GROUPS CONCERNS THE FITNESS AND QUALITY

OF THE HOSPITAL STAFF WHO ARE RESPONSIBLE FOR THEIR TREATMENT. THIS YEAR'S BUDGET APPEARS TO TARGET THIS PROBLEM. FOR EXAMPLE, IT PROVIDES $100 MILLION TO V.A. HOSPITALS, WHICH WILL ENABLE THESE HOSPITALS TO COMPLY WITH NATIONWIDE STANDARDS THAT RESTRICT RESIDENTS' WORK HOURS, IMPROVE THEIR SUPERVISION AND HIRE ADDITIONAL STAFF TO PERFORM DUTIES PREVIOUSLY PERFORMED BY RESIDENTS. WITH THE OBSERVANCE OF THESE STANDARDS, MANY PATIENT CARE PROBLEMS, WHICH RESULT FROM WORKER FATIGUE, SHOULD BE ELIMINATED. THE BUDGET FURTHER PROVIDES $143.7 MILLION TO REPLACE OLD EQUIPMENT, A PRIORITY REPEATEDLY CITED BY OUR V.A. HOSPITALS.

FINALLY, I WOULD LIKE TO POINT OUT THAT THE 1992 V.A. BUDGET MAKES SOME

IMPORTANT STRIDES TO HELP OUR OLDER VETERAN POPULATION BY INCREASING THE NUMBER OF NURSING HOME BEDS IN OPERATION BY 1,863. IT ALSO INCLUDES A PROPOSAL TO REFORM BENEFICIARY TRAVEL REIMBURSEMENTS WHICH WILL GENERATE $62.9 MILLION IN SAVINGS.

IN GENERAL, I AM VERY PLEASED WITH THE 1992 PROPOSED BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS. IT SHOULD ALLOW US TO IMPROVE OUR SERVICES TO OUR NATION'S VETERANS. HOWEVER, I ALSO BELIEVE THAT THIS YEAR'S BUDGET REQUEST COULD DO MORE.

AS WE ALL KNOW, THE OFFICE OF MANAGEMENT AND BUDGET (OMB) IS REQUIRED TO ESTIMATE THE AMOUNT OF BUDGET AUTHORITY AND OUTLAYS NECESSARY TO

SUPPORT A "CURRENT SERVICES" BUDGET. THIS IS A BUDGET IN WHICH NO POLICY CHANGES ARE MADE.

ACCORDING TO O.M.B., A "CURRENT SERVICES" BUDGET FOR 1992 WOULD REQUIRE AN ADDITIONAL $300 MILLION IN BUDGET AUTHORITY AND OUTLAYS ABOVE THE AMOUNT PROPOSED IN THIS YEAR'S BUDGET. WHILE I AM CONFIDENT THAT THE 1992 BUDGET WILL PREVENT THE FURTHER EROSION OF VETERANS' HEALTH CARE SERVICES, I AM NOT SO SURE IT WILL ALLOW US TO RECOUP THE GROUND WE HAVE LOST OVER THE LAST DECADE.

MR. CHAIRMAN, I LOOK FORWARD TO HEARING THE TESTIMONY FROM OUR VETERANS' SERVICE ORGANIZATIONS. MOST IMPORTANTLY, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THIS

COMMITTEE IN PASSING A VETERANS' BUDGET WHICH MEETS THE NEEDS OF THIS NATION'S VETERANS.

MIKE SYNAR
2D DISTRICT, OKLAHOMA

COMMITTEES
ENERGY AND COMMERCE
JUDICIARY
GOVERNMENT OPERATIONS
SELECT COMMITTEE
ON AGING

Congreſs of the United States
House of Representatives
Washington, DC 20515

WASHINGTON OFFICE
2441 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-2701

DISTRICT OFFICE
2B22 FEDERAL BUILDING
125 SOUTH MAIN STREET
MUSKOGEE, OK 74401
(918) 687-2533

TESTIMONY SUBMITTED TO THE HOUSE COMMITTEE ON VETERANS AFFAIRS DEPARTMENT OF VETERANS AFFAIRS BUDGET FOR FISCAL YEAR 1992

February 21, 1991

Mr. Chairman:

I am submitting testimony on behalf of the 150,000 veterans in the area of jurisdiction served by the VA Medical Center in Muskogee, Oklahoma, which has served the veterans of our Congressional district for over sixty years.

On the battlefield and in peacetime service, our nation's veterans have rendered a glorious legacy: the blessings of liberty, prosperity, and hope. Even today, American servicemen and servicewomen stand vigil in the Persian Gulf and elsewhere around the world to defend human rights from oppression.

We once made great strides in squaring our debt to those who have served this nation faithfully and honorably. In recent years, this has been a struggle. When budget resources are divided, veterans deserve a special consideration.

The Department of Veterans Affairs' medical system faces serious problems in its ability to maintain quality care and to provide timely access to care for all eligible veterans. From 1976 to 1990, outlays for veterans programs decreased from 5 percent of all federal outlays to only only 2.3 percent. Each year the VA medical account is threatened by automatic cuts mandated by Gramm-Rudman if Congress does not meet spending guidelines.

In response to these urgent needs, I consider the President's 4.7 percent increase in the 1992 budget proposal a welcome increase, but still inadequate to insure all veterans receive timely access and quality health care. The VA medical system has been plagued over the last ten years by deficient budgets which have generated critical staffing shortages, equipment replacement backlogs, and other resource problems.

As Congress develops its own budget, we need to take a good look at the recommendations offered by veterans themselves, such as the Independent Veterans Budget proposed by the Veterans of Foreign Wars, AMVETS, Disabled American Veterans, and Paralyzed Veterans of America. The American Legion has proposed a VA medical budget of $14.3 billion for FY92, almost $2 billion more hire additional health care providers and to allow pay increases for VA medical professionals. The remainder would be used for improving existing programs and eliminate the shortage of equipment and supplies.

Mr. Chairman, the spending plan finally adopted by Congress must enable the Department of Veterans Affairs to provide quality medical care and improve the services America's veterans have earned. In that task, veterans service organizations have provide us with appropriate guidelines for fiscal year 1992. I commend those recommendations to the careful consideration of this Committee.

Mike Synar

MIKE SYNAR, M.C.

STATEMENT OF

LARRY W. RIVERS
EXECUTIVE DIRECTOR
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE FY '92 DEPARTMENT OF VETERANS AFFAIRS BUDGET

WASHINGTON, D. C. FEBRUARY 21, 1991

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

This is the fifth year that we four veterans' service organizations have come together to formulate and present to the Congress our independent assessment of veteran needs and a responsible budget to meet those needs, through programs administered by the Department of Veterans Affairs (VA). Our organizations represent approximately 3,500,000 veterans. We are not only concerned with the well being of our members--we are concerned that all veterans receive health care and all other benefits to which they are entitled.

We acknowledge and truly appreciate the efforts of those within our Department of Veterans Affairs and those members of Congress who diligently work to obtain additional essential funding necessary to manage VA programs and provide veterans with needed medical care. The billion dollar increase for medical care last fiscal year and the proposed billion dollar increase this fiscal year are significant; however, these increases barely cover the costs of medical care inflation and do nothing to solve the serious problems in the delivery of other benefit programs. Those increases remain insufficient to maintain a now seriously eroded base of available medical care. We acknowledge that these are times of severe budget austerity; therefore, our proposals are realistic and responsible given the obligation of the federal government and meet the needs of veterans through programs promised and established for them.

This year we have taken a different approach in the benefits section. We propose a repeal of the "Omnibus Budget Reconciliation Act of 1990," veterans entitlement restrictions. In support of that we recommend far less painful savings of sufficient magnitude to meet Omnibus Budget Reconciliation Act savings plus suggestions to provide financial relief for VA as a whole. The problems of service to veterans will not be solved with the Omnibus Budget

Reconciliation Act, nor with the proposed FY 1992 budget. It will be necessary to take action such as we recommend in the Independent Budget to stem the tide that is seriously eroding all veterans entitlement programs. The service and benefits shortfalls resulting from inadequate funding, which we predict in this and prior Independent Budgets, have been uncannily correct. For this reason alone, if for no other, no one can truthfully say that veterans are only looking for more or that they are never satisfied. Our satisfaction will be evident when the federal budget programs are corrected to meet the nation's commitment to those who serve.

Veterans have become weary of constantly being told that federal funding is increasingly austere and that requirements of other budget accounts are as valid as veterans program. Today, thousand of young Americans are being asked to match the sacrifices of the millions of veterans who served in defense of this nation before them. Now, more than ever, we believe it is essential that our government maintain the quality and quantity of veterans' benefits and services through top priority funding equal to, if not greater than, provided other federal sponsored programs. If we are first during time of war, we should likewise be first during times of peace. As a grateful nation, we must live up to our President's State of the Union words about the servicemen and women in the Persian Gulf. "Our commitment must be the equal of their commitment to their country, They are truly America's finest." And that applies as well to those who have served before them.

At this time, I will discuss the Independent Budget recommendations for VA's construction programs.

MAJOR CONSTRUCTION--The Independent Budget recommends $700 million for major construction or $250 million more than the $450 million recommended by the Administration. The total major construction appropriation continues to deteriorate as the Administration is requesting $130 million less than what was enacted last year. Our source for FY 1992 funding projections is VA's current five year plan, which we believe may not meet the priorities that an in-depth analysis of national requirements might ultimately reveal. However, for VA to achieve less in FY '92 than what is called for in the five year plan, in our opinion, would be catastrophic. We base this assumption on the limited current replacement cycle, rapidly changing clinical requirements, and existing physical plants' excessive age.

Within the $700 million major construction total, we recommend that Congress allocate $44 million for the Advance Planning Fund and the Design Fund, as compared to only $11.5 million as requested by the Administration. Of particular concern to us is the Administration's request for only $7.7 million dollars for advanced planning. This barometer only serves to confirm our suspicions of the Administration's lack of commitment and foresight in providing for the future needs of our nation's veterans. The gross underfunding in this area does nothing but impede the consideration of future construction projects and turns a deaf ear to the cries of today's veterans and those who will be tomorrows veterans for modern and efficient VA facilities. For Congress to support a strong planning and design program will enable VA to build more of the major construction projects it desperately needs.

The FY 1992 Independent Budget also requests $33 million for the construction of new VA nursing homes. While the FY '92 Administration proposal calls for several renovation projects, we note there is no funding for any new VA nursing homes. We continue to advocate funding that will permit VA to construct four 120-bed nursing homes this year and an equal number each subsequent year through this decade.

Finally, our major construction proposal includes $6.6 million to acquire land for national cemeteries in states that have none. We recommend VA purchase and construct two new national cemeteries annually until the national cemetery system meets our previously stated goals of an open national cemetery in every state.

The remaining $616 million of the major construction appropriation should be devoted to helping reduce the other five year plans FY 1992 medical construction requirements.

MINOR CONSTRUCTION--The FY '92 Independent Budget recommends a $320 million appropriation for minor construction as compared to the Administration request of $195.7 million. The Independent Budget's recommendation significantly exceeds the Administration request so as to include funds for the tremendous backlog caused by the $15 million reduction in the Department's FY 1991 budget. This increase reflects our growing concern about VA facilities' urgent updating and repair needs. Most VA facilities were constructed during the 1950's and therefore the need for update and repair is increasing rapidly. Compounding the problem are earlier minor construction appropriations having fallen far short of addressing these urgent needs.

As with the Administration proposal most of the Independent Budget recommended minor construction funds, $253 million, are earmarked for medical construction. This would include areas such as asbestos abatement, electrical improvements, fire and safety improvements, seismic improvements, etc.. The FY 1992 Independent Budget also recommends $56 million of this amount be used to convert unused medical center beds to nursing home care beds. This amount should be sufficient to convert 2,500 beds this fiscal year. While we recommend an annual conversion rate of 1,000 beds during the next several years, the increased amount of 2,500 beds this fiscal year reflects our concern that VA did not achieve last year's Independent Budget's recommendation of a 1,000 bed conversion.

We request modest amounts within the construction appropriation to support VA regional office and national cemetery construction projects. The FY 1992 Independent Budget recommends $6 million and $11 million, respectively, for these purposes. Finally, the Independent Budget recommends $63 million in minor construction funds for VA construction staff, primarily within the office of facilities. This funding level should permit staffing at current levels and allow for the appropriate steps to be taken to establish national construction priorities, and improve construction and planning.

PARKING GARAGE REVOLVING FUND—The FY 1992 Independent Budget recommends a $25 million allocation to this fund which finances VA facility parking garage construction and operation. Inasmuch as it is anticipated parking garage revenues will pay for new projects, future allocations for this fund should diminish. However, only a few revenue-producing projects currently exist, so VA needs limited new appropriations.

This concludes my statement. I will be happy to respond to any questions you may have.

STATEMENT OF
JESSE BROWN
EXECUTIVE DIRECTOR
WASHINGTON OFFICE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
FEBRUARY 21, 1991

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.3 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to have this opportunity to present our views on the budget request of the Department of Veterans Affairs (VA) for Fiscal Year (FY) 1992.

As you are aware, Mr. Chairman, on behalf of the VA, the President is requesting $33.2 billion in budget authority and $32.2 billion in appropriations for FY 1992 to administer various benefit programs for this nation's 72.9 million veterans, their family members and survivors of deceased veterans. This represents an increase of $1.2 billion in budget authority and $851 million in appropriations over FY 1991 enacted levels.

Like last year, this is a substantial increase for which we are grateful but, like last year, the requested increase in budget authority and appropriations is largely illusory. For example, an increase of $977 million for medical care is requested, but approximately 88 percent of this increase is specifically earmarked for increased payroll costs for existing employees ($581 million) and inflation costs ($280 million). Of course, this increased funding is desperately needed but it continues to be too little and comes too late to rectify decade-long funding deficiencies.

Mr. Chairman, this is the fifth consecutive year that four Congressionally chartered veterans' service organizations (VSOs) have prepared a needs-based budget document to more accurately reflect the funding levels necessary to adequately deliver benefits and services to our nation's veterans. The Independent Budget project, a complex and difficult undertaking, became necessary due to past Office of Management and Budget (OMB) dominated budget submissions that resulted in a frightening trend of grossly inadequate delivery of health care and benefits and services for those who in the past have served in the Armed Forces of this nation.

Mr. Chairman, since I testified on the VA's FY 1991 budget request last year two major events have occurred which will have a profound effect on VA's ability to provide medical care and benefits and services to veterans. One, of course, is Operation Desert Storm with half a million of our men and women in the Armed Forces now engaged in war in the Persian Gulf.

In his State of the Union Address, the President paid a moving tribute to our troops in the Persian Gulf, praising their courage and willingness to sacrifice to do the "hard work of freedom." Mr. Chairman, when the peace is won and our troops come home, what kind of medical care and benefits and service delivery can they expect from VA? If they receive the same level of medical care and services as veterans who have already done the hard work of freedom are now receiving from the VA, it will be a national scandal.

In last year's testimony, I illustrated this point by focusing on a hypothetical veteran of our then recent Panama engagement, "Corporal Jones," who sustained a gunshot wound injury necessitating an above-knee amputation prior to release from service.

Corporal Jones' journey through the VA system was as follows:

> During 1990 he will contact the VA to file a claim for benefits. When he calls the VA, he may be one of the 1.7 million veterans who are unable to access the Veterans Services Division (VSD) due to a series of reductions in Full-Time Equivalent Employees (FTEEs) and lack of budgetary support for state-of-the-art telecommunication equipment. If he is unfortunate enough to live in 24 of the 75 largest metropolitan areas of our country with no VSD counselors, he will not be able to arrange a personal visit to discuss his potential benefits. When he finally gets through and files a claim, his may be one of the 30% of compensation claims that requires in excess of 180 days to complete, due to staffing shortages. Since he is not working and lacks a college education, "Corporal Jones" will file an application for vocational rehabilitation training. He will find he must wait 100 days just to be interviewed by a vocational rehabilitation counselor.
>
> Months after service, "Corporal Jones'" VA physician advises him that a new prosthesis is required to fit his stump. Upon contacting his VA prosthetic department, "Corporal Jones" finds his name on a lengthy waiting list of those needing a prosthesis, since the local VA medical center does not have the funds necessary to timely furnish its patients prosthetic devices for their service-connected disabilities.

Mr. Chairman, for a Corporal Jones returning home from the Persian Gulf, little has changed. In 1991, he may have a slightly better chance of actually talking to a Veterans' Benefits Counselor on the phone, if he is persistent, but his compensation claim will take longer to decide. Currently, almost one-third are not decided within six months.

Mr. Chairman, is this the level of service Persian Gulf veterans deserve? Of course not. Why then is this the level of service that is being provided to veterans who have done the hard work of freedom during past wars? We understand that the Veterans Benefits Administration (VBA) has developed a plan to expedite benefits and services delivered to Persian Gulf veterans. However, there are no additional employees to do this and, therefore, the benefit claims of other no less-deserving veterans will be delayed further from already unacceptable levels. This is not the solution. The solution is to provide VA with the resources needed to process the claims of all veterans in an accurate and timely manner.

The second major event was the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA). OBRA is the enacted legislative plan for deficit control over the five-year period from FY 1991 to FY 1995. OBRA includes a combination of spending cuts and tax increases that are designed to achieve specific deficit reduction targets. Under OBRA, the VA's budget authority for FY's 1991-1995 has already been set and, under the provisions of Title XIII (The Budget Enforcement Act of 1990), authorizing and appropriations committees are required to adhere to those spending limits. Obviously, OBRA ushers in a new era of budget making, which will have a profound impact on VA.

Mr. Chairman, any discussion of the VA's FY 1992 budget request must begin with an analysis of OBRA. In formulating the

FY 1992 Independent Budget (IB), the participating VSOs have agreed to take responsibility for preparation of separate elements of the budget. DAV's areas of responsibility are Benefits' Programs and General Operating Expenses (GOE). OBRA has had a direct and adverse impact on these budget areas and the IB therefore contains a detailed analysis of this legislation.

OBRA was the product and culmination of the Budget Summit negotiations which occurred throughout most of 1990. As you are aware, Mr. Chairman, these negotiations were conducted by Administration participants and the Congressional majority and minority leadership rather than within the normal legislative process, which includes public hearings such as this where interested parties can state their views.

In any event, during the seemingly interminable negotiations, two messages were sent by the participants: (1) they were serious about meaningful and sustainable deficit reduction and, (2) spending cuts and/or tax revenues must be fair and equitable.

Mr. Chairman, veterans have displayed the same selflessness in confronting the deficit crisis as when they answered their country's call to arms. DAV has repeatedly stated that veterans are willing to pay a proportionate share in reducing the deficit, despite the sacrifices they have already made in doing the "hard work of freedom." With the leadership of both major parties apparently being committed to fair and equitable deficit reduction action, veterans were willing to pay their share. We fully expected, however, that other federal entitlement programs would contribute to deficit reduction and that the array of federal grants and pork-barrel projects would be pared to the bone, if not eliminated, at least until deficit reduction targets were achieved. I'm sure you will agree, Mr. Chairman, that those were not unreasonable expectations. I also believe that you and the other members of this Committee shared similar expectations.

You can appreciate our shock to discover, after examining the over 1,200 pages of OBRA's Conference Report, that veterans' entitlement programs had been singled out for deficit reduction. Other entitlement programs, like Social Security, not only escaped cuts, they have been enhanced. In fact, a knowledgeable observer of Social Security programs has told me that OBRA enacted the wish list of Social Security claimant and beneficiary advocates.

The IB analyzes the unfairness of these entitlement cuts in detail but I'd like to give you some examples of how compensation and DIC beneficiaries, whose eligibility is based on a veteran having a service-connected disability, have been singled out to bear the burden of deficit reduction.

A ONE-MONTH COLA DELAY. FY 1991 SAVINGS OF $49 MILLION.

- VSOs are the only advocacy group that said we would accept a COLA delay/cut if it was applied to all other federal programs. Our reward: veterans are the only group whose COLA was affected.

- If deficit reduction is Congress' goal, a one-month delay of Social Security non-means tested OASDI benefits would save $980 million. Total monthly OASDI payments are twenty times greater than compensation and DIC payments (20 X $49 million = $980 million).

Limiting Estates of Incompetent Veterans - Savings: $125 million in FY 1991 and $291 million in FYs 1991-1995.

- This provision is directed at the most vulnerable of all compensation recipients.
- Compensation is not a needs-based program, but this provision imposes such a test on incompetent veterans.
- Veterans alone have been targeted. Why wasn't the same approach applied to non-needs based Social Security benefits?
- There are 116,000 fiduciaries receiving compensation on behalf of incompetent veterans but there are over 3.3 million representative payees receiving OASDI benefits on behalf of beneficiaries.
- While Congress was passing legislation to take compensation from incompetent veterans, it was also passing legislation to reform the Social Security representative payee system to enhance the rights of incompetent beneficiaries and ensure that all of their benefits are used in their best interests.

Eliminating compensation for the "secondary" effects of willful misconduct. Savings: $10 million in FY 1991 and $334 million in FYs 1991-1995.

- Here, again, only veterans have been singled out and only those who apply for service-connected disability (Pension applicants are not affected by the provision).
- If the intent is not to pay benefits based on disabilities resulting directly or secondarily from the applicant's willful misconduct, why was this provision not applied to the far more numerous Social Security disability applicants?

Repealing the provision which permitted reentitlement to survivors' benefits upon termination of a former spouse's or child's marriage. Savings: $19 million in FY 1991 and $374 million in FYs 1991-1995.

- The remarriage provision being repealed was already the most restrictive among federal benefits programs.
- For example, Social Security permits remarriage generally at age 60 and as early as age 50 in many instances and Civil Service permits remarriage at age 55 without any penalty. Both provide for restoration of eligibility upon termination of the remarriage, regardless of age.
- Now, surviving spouses of those who died in combat or as a result of service-connected disability, alone among all federal program beneficiaries, are foreclosed from receiving veteran's survivor's benefits if they remarry, regardless of their age or financial circumstances.
- To further illustrate the inequity: While Congress was passing this provision, it was liberalizing the remarriage provision under the CIA Retirement and Disability System (CIARDS) "to provide greater consistency with other federal retirement programs." The age at which remarriage would not affect eligibility was lowered from 60 to 55.

- OBRA also significantly liberalizes the definition of disability for Social Security surviving spouses.

LIMITING VOCATIONAL REHABILITATION TO VETERANS WITH SERVICE-CONNECTED DISABILITIES RATED 20 PERCENT OR MORE. SAVINGS: $20 MILLION IN FY 1991 AND $180 MILLION IN FY 1991-1995.

- This is not really cost-effective. The greatly increased earnings of vocationally rehabilitated veterans result in greatly increased tax revenues, which will be lost.
- Provision targets 10-percent rated veterans, who are the ones most easily rehabilitated.
- The provision is a major recision of the program; veterans with 10-percent service-connected disabilities, account for 30-percent of the veterans in the program.
- The provision is contrary to public policy which not only encourages but in many instances requires vocational rehabilitation.
- While veterans VR is being cut significantly, OBRA has a provision requiring SSA to conduct demonstration projects permitting disabled beneficiaries to select a qualified VR agency, public or private, to provide them VR services.

The list goes on, Mr. Chairman. Veterans' pension entitlement was restricted by eliminating the presumption of total disability at age 65, whereas the needs-based Social Security counterpart, Supplemental Security Income (SSI), was not. In fact, OBRA liberalizes several SSI income and work incentives provisions. Now needy aged wartime veterans alone among all federal entitlement and retirement programs must establish that they are totally disabled to receive benefits. Even burial benefits were targeted with the elimination of headstone/marker and plot allowance.

All of these cuts, limit or restrict entitlements that were based on a veteran having a compensable service-connected disability or having served his or her country in the Armed Forces during wartime, Surely, Mr. Chairman, in any rational system of priorities, these benefits would be the last to be cut. That they were the only entitlements to be cut is not only unfair but unconscionable.

Finally, not even the Home Loan Guaranty veterans' entitlement escaped OBRA. The basic loan user fee was increased by 50 percent, less than a year after it had been raised in connection with legislation establishing the Guaranty and Indemnity Fund (GIF).

Mr. Chairman, the VSOs recognize that, in connection with OBRA, this Committee had the thankless task of producing reconciliation legislation that would result in savings of $620 million for FY 1991 and $3.35 billion for FYs 1991-1995. This had to be done and it had to be done quickly and in isolation from other authorizing committees.

This environment neither invited nor permitted sober analysis of what was being done and whether there were alternatives which would be at least as effective in reducing the deficits but more fair and less harmful to veterans and their dependents. This is the kind of analysis that the IB has been providing but was not available to Congress at a time when the budget process was taking an historic turn in the name of deficit reduction.

Only now is it possible to analyze what has been done and, accepting the reality of deficit reduction ask the question: Is there a better way? The VSOs are convinced that there is a better way and have developed an alternative deficit reduction plan, which is the centerpiece of the FY 1992 IB.

The VSO's Deficit Reduction Plan

Mr. Chairman, the cornerstone of the VSO's deficit reduction plan is our analysis and interpretation of the requirements and intent of OBRA and our application of both the letter and spirit of this landmark legislation to Veterans Programs and the mechanism by which they are delivered, the VA's budget.

There are many good things about OBRA. By all accounts, if its terms are adhered to, it will make the budget process more stable and rational. It sets five-year spending limits, which allow agencies like VA to know what their budget authority for those years will be and to plan accordingly. Most importantly in our view, as long as spending limits are not exceeded, it allows authorizing committees considerable flexibility in determining spending priorities and finding revenue sources to fund them. In doing so, it loosens the iron grip of the appropriations process on entitlement programs delivery because internally-generated savings exceeding deficit reduction targets are not appropriations.

OBRA therefore permits internally-generated savings, in addition to the already set budget authority, to be used for entitlement enhancements and/or additional resources to improve the delivery of them. As we see it, this is what the pay-as-you-go provisions of OBRA's Title XIII (The Budget Enforcement Act of 1990) are all about.

These are the underlying premises of the VSO's deficit reduction plan. Some may characterize the plan as perhaps innovative but wishful in its savings estimates. We think not. The savings we have identified are not only real but conservative estimates and meet both the letter and spirit of OBRA's requirements. We invite your close scrutiny of the plan.

An important element of the plan is the recognition of the dynamics and demographics of the compensation and pension rolls. A basic tenet of OBRA is that domestic spending will be allowed to rise with the rate of inflation, albeit after enacted deficit reduction targets are met.

Compensation and pensions outlays represent approximately half of the total VA budget. Based on the past five-years actual experience (FYs 1986-1990) and the demographics of eligible and potentially eligible recipients, however, it is clear that during FYs 1991-1995, compensation and pension outlays will rise at considerably less than the inflation rate. During FYs 1986-1990, pension outlays, even after COLAs, did not rise at all and compensation outlays rose an average of 2.3 percent a year. (FY 1991 compensation appropriations of $11.5 billion are $152 million less than FY 1990 obligations.)

The VSOs conservatively estimate that actual pensions obligations will decrease one percent per year during FYs 1991-1995 and compensation obligations will rise no more than 2.3 percent per year (as they did during FYs 1986-1990).

The budget authorities for FYs 1991-1995, which have already been set, incorporate OBRA's deficit reduction targets and allow spending to use with inflation. Therefore, entitlement outlays that are proportionately less than those limits can and should be credited as savings.

The IB does so as follows using FY 1990 obligations as the constant, non-inflated baseline:

	Savings (in millions) FY 1991	FYS 1992-1995
Pensions		
a. Outlays less than inflation	138	822
b. Decrease in outlays from FY 1990 base	40	200
Compensation		
Outlays less than inflation	480	1,389
TOTAL	658	2,411

Mr. Chairman, the other elements of the VSO plan are considerably less complex. The plan incorporates the OBRA provisions relating to the COLA delay, the IRS income match (with no sunset date), the social security number death verification, and the Medical-Care Cost Recovery, with their associated savings, which are based primarily on CBO estimates.

We must note, however, that although the VSOs support the IRS match provision for the legitimate program purposes identified in the Conference Agreement Report and, indeed, recommend that it be made permanent, we are puzzled as to why the phrase "or any other law administered by the Secretary of Veterans Affairs" was added to the statute. This goes beyond the scope of the Conference Agreement, and we strongly object to this all-inclusive use of IRS and Social Security income data.

The only legitimate program uses for the data have been identified in the Conference Agreement. Under no circumstances should compensation recipients, whose net worth and earnings from employment are irrelevant to their compensation entitlement, have their right to privacy violated by being subject to this provision. Since no reason has been identified in the Conference Agreement or elsewhere for insertion of the phrase, "or any other program administered by the Secretary of Veterans Affairs," and because it creates great potential for privacy right violations, Congress should strike it from the statute.

The VSOs also observe that Section 3117 calls for a GAO study "of the effectiveness of the amendments made by this section." The Conference Agreement made no mention of a GAO study, and we fail to see the need for one. Certainly the VA's Office of the Inspector General can and will conduct such a study and limit it to legitimate program purposes.

The remaining elements of the VSO plan require administrative and legislative reforms of the Home Loan Guaranty Program. For years, the VSOs have been frustrated by the continuing deficits in this program (a total of $4.42 billion since 1984) when the solution for reducing if not eliminating these deficits was so obvious: Provide VA with a sufficient number of employees to administer the program in the interest of its intended beneficiary, the veteran.

The best and latest evidence of this comes from VA in its report to OMB on the first 12 months experience of the Houston Pilot Servicing Project. Mr. Chairman, the report documents direct program savings of $11,224,463 resulting from the work of ten additional employees. These savings resulted from 559 successful interventions (direct contact with the lender regarding delinquent loans where foreclosure was avoided). After deducting personnel and equipment costs, documented savings per additional employee were $1,091,546.

VA estimates that at least as many foreclosures were avoided through personal supplementing servicing assistance which made direct intervention with the lender unnecessary. This, of course, would double the savings, and mean that more than 1,100 veterans and their families, who otherwise would not have, kept their homes.

Mr. Chairman, rarely do the goals of deficit reduction, program integrity and efficiency, and good service to veterans coincide so exactly. However, ironically, but not uncharacteristically, just as management initiatives and, most importantly, additional employees were predictably improving loan servicing and providing major program savings, the Administration's FY 1992 budget requests 114 fewer FTEEs for Loan Guaranty. In the face of the indisputable evidence regarding the savings generated by additional employees, the VA's budget request for fewer employees can only be characterized as "killing the goose that lays the golden eggs."

Mr. Chairman, the VSOs intend to take advantage of this golden-egg laying goose and, as part of our deficit reduction plan, we are recommending 150 additional FTEEs for improved loan servicing. Based on the results of the Houston Project, the plan credits $1.1 million per year in direct savings and $400,000 of the estimated $1.1 million in default avoidance savings per each additional employee (prorated for FY 1991). Savings would be $100 million for FY 1991 and $225 million for each year from FY 1992-1995, for a total of $1 billion.

We are also recommending legislation to include resale losses in net value for purposes of the formula used to determine whether VA will acquire a foreclosed property (the no-bid formula). This is more preferable than veterans paying ever-increasing user fees for an entitlement earned by service in the Armed Forces and would produce much greater savings than the enacted increased user fees.

The fear has been expressed that this provision would affect some lenders' willingness to make VA-guaranteed loans and therefore limit the number of veterans able to use their VA entitlement to buy homes. The VSOs believe that this is something to strive for rather than fear. VA-guaranteed loans made by responsible lenders to credit-worthy veterans are not the problem; indeed, this is exactly what the program is intended to do. The problem is the practice that encourages lenders to make marginal or bad loans, with virtually no risk to the lenders in the event of default/foreclosure.

Mr. Chairman, not one dime of the $4.42 billion deficits since 1984 has gone into the pocket of a veteran. As we see it, the no-bid formula would place an element of risk where it belongs -- with the lenders who have been major beneficiaries of the program. We believe it will also serve as an effective deterrent to making bad loans because of the risk involved in continuing this practice, and it will automatically improve lender underwriting standards.

CBO advises that VA's savings estimate from this provision is $80 million for FY 1991 and $445 million for FYs 1991-1995.

Mr. Chairman, those are the elements of the VSO deficit reduction plan. The savings total $1.094 billion for FY 1991 and $5.711 billion for FYs 1991-1995. They greatly exceed OBRA targets and can be achieved without any of the entitlement cuts enacted by OBRA. The IB recommends repeal of all these entitlement cuts. It also recommends that the savings in excess of OBRA targets be used to fund the VSO's legislative proposals and to improve VA health care and benefits and services delivery.

The VSOs are convinced that had Congress had the plan before them, as it would have in the normal legislative process, Veterans Programs deficit reduction would not have been enacted in its present form. A solid, realistic alternative has now been presented and we ask your careful consideration and support of it.

General Operating Expenses

Veterans Benefits Administration (VBA)

Mr. Chairman, the fine work this Committee did in analyzing the VA's FY 1991 budget request has made the job of the VSOs much easier in preparing the FY 1992 IB. The Committee's incisive and comprehensive Report to the Budget Committee on the VA's FY 1991 budget request identified the many holes in VBA's benefits and service delivery dike and the resources that were needed to begin closing those holes. The FY 1992 IB relies heavily on and quotes extensively from the Committee's Report because, unfortunately, there has been little change in our assessment of VBA's service to veterans during the past years.

The same problems remain for the same reason -- VBA did not receive appropriations support for the FTEEs it needs to provide adequate service to veterans. The FY 1992 budget request offers no relief. Before addressing the FY 1992 budget request, however, it is necessary to discuss what occurred after FY 1991 appropriations were enacted.

FY 1991 enacted appropriations supported a VBA FTEE level of 12,550, 839 fewer than recommended by the IB and 361 fewer than recommended by the Committee. OBRA, however, with its innovative mechanism for funding the administrative implementation costs changed the situation radically.

The statute authorizes VBA to be reimbursed for the administrative costs of implementing OBRA's provisions from "amounts available to the Department of Veterans Affairs for the payment of compensation and pension." As if by magic, Mr. Chairman, VBA's FTEE level soared to the current estimate of 13,107. I'm sure this Committee appreciates, as we do, the stark contrast between the ease with which OBRA's funding mechanism provided virtually a blank check for additional FTEEs, and the futility of our past best efforts to even maintain inadequate VBA FTEE levels through the "normal" appropriations process.

At first glance it would appear that VBA is finally getting the FTEEs it needs to provide good service to veterans. This, however, is not the case. All of the additional employees have been earmarked to implement OBRA's deficit reduction provisions during FY 1991. Under the FY 1992 budget request this will not change.

The Administration's budget request calls for a VBA employee level of 13,140, an increase of 33 over FY 1991. However, this includes a net increase of 333 employees in Information Resources Management (formerly ADP Management) resulting from a transfer of 356 employees from a non-VBA component, the Office of the Assistant Secretary for Information Resources Management. Also, 307 employees are earmarked for implementing OBRA provisions in FY 1992.

Therefore, VBA employees added by transfer and those dedicated to implementing OBRA's deficit reduction provisions total 726. Subtracting this number from the FY 1992 budget request results in an employee level of 12,414. This is 267 fewer employees than the FY 1990 actual employee level of 12,681.

After all the smoke and mirrors are removed, the fact is that VBA will have fewer employees to adjudicate claims, answer veterans' calls, service loans and provide vocational rehabilitation counseling to service-connected disabled veterans. There will, however, be more than enough employees to implement OBRA's deficit reduction provisions by collecting overpayments and enforcing entitlement cuts and restrictions.

To add insult to injury, Mr. Chairman, VBA's FTEE request has been reduced by 60 due to workload decreases (all of which are attributed to OBRA's entitlement restrictions) and 125 due to modernization "savings." Both reductions are directly counter to recommendations made in this Committee's Report on the FY 1991 budget request. The Committee recommended that FTEE cuts due to modernization savings be restored and in commenting on the then proposed legislation for an IRS income match, the Committee stated:

> The Committee wishes to emphasize that this proposal will not be reported unless the resulting savings are made available for discretionary programs in the veterans function.

Mr. Chairman, I believe the Committee's statement applies to OBRA-generated workload decreases. It also clearly supports the IB's position that savings in excess of deficit reduction targets identified in the VSO plan, be maintained and used by VA to improve service to veterans.

Mr. Chairman, we have grown weary of pleading for additional VBA FTEEs, which a cynical and unresponsive budget process refuses to provide. If our pleas again go unanswered at a time when Operation Desert Storm graphically reminds the nation what the "hard work of freedom" entails, veterans can only feel a sense of despair.

With this in mind, a major IB recommendation is the enactment of the Veterans Benefits Administrative Equity Act of 1991, which has been introduced by Representative Bob McEwen. This legislation provides for the payment of interim benefits if compensation and pension claims are not decided within six months and also provides that VA must contract with accredited non-VA agencies for eligible veterans' vocational rehabilitation services if VA is unable to interview eligible veterans within 60 days.

The VSOs believe this bill is a major breakthrough. It would end the stranglehold OMB and the appropriations committees in general have had on the budget process, by making reasonable service expectations the baseline for budget formulation. As we see it, enactment of the bill will serve several purposes. It would:

(1) Recognize in equity and law that veterans and their survivors and dependents are entitled to have VA decide their claims within reasonable time limits;

(2) Compel Congress to define the minimum level of services it expects VA to provide veterans and their survivors and dependents in deciding their claims, given existing budgetary constraints; and to periodically modify those expectations, as necessary and appropriate;

(3) Provide equity in a meaningful way to individuals whose claims are unduly delayed through no fault of their own, and impose a penalty on VA if a claim is not decided within a specified time;

(4) Provide VA an incentive to develop claims adjudication policies and procedures that enable VA to use existing and planned resources to decide claims as effectively and fairly as possible;

(5) Establish commonly-recognized standards of service delivery which will enable Congress to discharge its oversight and appropriations responsibilities more effectively.

The timeliness standards set in the bill are, we believe reasonable by any definition. If VA meets those standards, the bill has no associated costs. Indeed, this is the goal. If VA does not meet the standards, the interim benefits are a small price to pay for the years of budgetary neglect to which veterans have been subjected.

The McEwen bill will not address all of VBA's problems. As this Committee so persuasively demonstrated in its Report on the FY 1991 VA budget request, the Veterans Services Division (VSD) desperately needs additional employees to personally and by phone provide benefit information to veterans and to conduct Congressionally-mandated outreach programs. The FY 1992 IB repeats its and this Committee's FY 1991 recommendation that appropriations be provided to support an additional 195 VSD FTEEs.

As stated above, the FY 1992 IB also recommends an additional 150 FTEEs for Loan Guaranty (the Administration recommends a decrease of 114). This is a major element of our deficit reduction plan and under OBRA's Credit Reform Act, funding for this recommendation would be in the form of reimbursements from Loan Guaranty Housing appropriations. Under credit reform all administrative costs of Loan Guaranty will be so funded. This is appropriate because the savings associated with improved loan servicing will be directly reflected on the bottom-line of reduced program costs.

These are the IB's FY 1992 VBA recommendations. We would be remiss, however, if we did not report some good news. VBA's systems modernization plan appears finally to be on track and producing positive results. The VSOs believe that this activity is being innovatively managed. We stress, however, that positive results are being achieved because this activity is adequately funded and staffed.

The National Cemetery System (NCS)

Here, too, the VSOs have relied on this Committee's Report on the FY 1991 VA budget request. The Committee recommended an additional $15 million over the Administration's FY 1991 request of $54.8 million for this very well-managed but grossly underfunded component.

As you are aware, Mr. Chairman, after the appropriation dust settled, NCS received $53.5 million for FY 1991. This is simply disgraceful. Because of the grossly inadequate FY 1991 appropriation, the shortfall for FY 1992 will be even worse.

The Administration's FY 1992 budget request of $57.3 million obviously can only make a crisis situation worse.

Mr. Chairman, it is disturbing that at the same time we are asking young men and women participating in Operation Desert Storm to place their lives on the line, the Administration has requested funding for the National Cemetery System that will result in the appearance of our national veterans' cemeteries being well below acceptable standards. The IB recommends FY 1992 NCS appropriations of $71.9 million but recognizes that this may understate NCS's needs because it addresses only the FY 1991 shortfall.

General Administration

Mr. Chairman, the VSOs have no specific recommendations to make regarding General Administration; however, we do have some observations.

The area within General Administration that has the greatest direct impact on veterans is the Board of Veterans Appeals (BVA). There are major timeliness problems in processing appeals but this primarily is regional office-related and not attributable to BVA (see GAO Report, GAO/HRD-90-62 - "Improved Management Needed to Reduce Waiting Time for Appeal Decisions," May 1990). The McEwen Bill addresses this problem by imposing timeliness standards which, if not met, will result in interim benefits being paid until the claim is decided.

As with initial claims, this is the best solution because it places the burden where it properly belongs -- with VA and not the veterans -- to achieve reasonable claims processing times. VA, acting with Congress, will have to determine the FTEE levels and other resources it requires to meet reasonable timeliness standards. If requested and appropriated resources prove to be insufficient, VA and not the veteran will pay the penalty.

Veterans' Health Services and Research Administration

Mr. Chairman, as we are all keenly aware, this is the second straight year the President has requested a near $1 billion increase for the purpose of attempting to meet the health care needs of our nation's veterans.

The DAV is most appreciative and supportive of the current request for increased funding. Clearly, however, we painfully witness the continued failure and apparent lack of commitment to recommend sufficient funding levels to substantially reverse the decade old trends of decremental funding which has led to a clear erosion of services provided by the VA's health care system.

Mr. Chairman, for FY 1992 the President's request for the Veterans' Health Services and Research Administration (VHSRA) calls for an overall appropriation request of $13.7 billion -- an increase of $1 billion over the current estimate for FY 1991.

This proposed request will support a total average employment of 202,129 FTEE, an increase of 1,399 over FY 1991 estimated levels (this increase includes 278 additional FTEE for a total of 1,578 FTEE that will be dedicated to the collection of insurance payments and copayments from veterans using the VA health care system).

Medical Care

Mr. Chairman, the FY 1992 request for medical care totals $13.3 billion and 196,114 FTEE -- increases of $976.6 million and 1,476 FTEE respectively over the FY 1991 levels.

It is our understanding, Mr. Chairman, that of the total requested increase, $860.5 million is being requested and earmarked specifically for increased payroll costs for existing employees ($581 million) and increased costs, other than personnel, due solely to inflationary factors ($280 million).

Simply stated, approximately 88 percent of the requested increase in the medical care account is planned to be spent for purposes that have little if any direct meaningful impact on disabled veterans.

It is our best estimate, Mr. Chairman, that the President's proposed budget request continues to fall far short -- by approximately $800 million -- of what is actually required to enable VA to provide health care at current services levels.

Additionally, the Administration's request is approximately $1.7 billion under the levels recommended by the Independent Budget which we feel is necessary to provide an adequate level and range of services to disabled veterans.

Therefore, the VA's ability to provide quality and timely health care services to entitled veterans will only continue to erode should this budget request be accepted in its current form. Disabled veterans will continue to be the victims of a system dedicated to the care of veterans, but constrained by the harsh realities of severe staffing and funding deficiencies.

Definitive information has been made available that paints a clear, albeit disturbing picture:

- VA Medical Centers continue to absorb funding shortfalls that adversely impede the delivery of health care.
- Incredible backlogs of needed but unable to be purchased medical equipment.
- Waiting times of up to nine months to be seen and treated in certain outpatient clinics.
- Nurse vacancies, as well as vacancies and severe recruiting difficulties for certain physicians and collateral health care providers.
- Intolerable delays in performing elective surgeries.
- Unused or underutilized space due to the lack of activation funds.
- The growing inability to meet the needs of veterans requiring long term care.
- Restrictions in receiving medications and/or supplies.
- Inequities in access to care.
- Veterans are outright being denied needed medical care.

Mr. Chairman, the inadequacy of funding for the VA's health care system is well known to you and members of this Committee. Such inadequacies and the adverse results have been vividly portrayed and defined on various occasions by many individuals ranging from members of Congress to Veterans' Service Organization representatives to VA health care providers to the most knowledgeable of all, the disabled veteran consumer.

As we have stated, this budget request is welcomed in the context of preventing significant further erosion of the system. It does not, however, go far enough.

In this respect, Mr. Chairman, we would further urge you to carefully consider the recommendations and funding and staffing levels as contained in the Independent Budget which has been provided to the Committee. It is our sincere belief that realistic funding levels are described that would allow the Department to carry out its mandated mission of providing health care services to disabled veterans.

Medical and Prosthetic Research

Mr. Chairman, the President's FY 1992 budget request for medical and prosthetic research totals $216.8 million -- an identical amount to already inadequate current year funding levels.

In the face of a clearly decremental research budget a reduction of 348 FTEE will occur. Also, the number of approved research projects will decline from 2,275 in FY 1991 to 2,037 in FY 1992, a reduction of 238 projects that will not be undertaken.

This budget request is totally unacceptable. Not only have the existing positive and beneficial aspects of VA research been ignored so have the recommendations made by the Blue Ribbon Commission established by the Secretary to review VA's research policy and budgetary needs.

Mr. Chairman, we urge you to disregard this blatantly inadequate research budget. Rather, we request the Independent Budget's recommended appropriation of $282.7 million be carefully scrutinized and adopted by the Committee. It is our belief the VA research program's decline needs to be halted and realistic funding levels be established to preserve the program's viability and ultimately enhance the quality of health care, as well as the quality of life provided to disabled veterans.

Construction

Mr. Chairman, the proposed construction budget for FY 1992 totals $654.2 million ($450 million for the major construction program, $195.7 million for the minor construction program and $8.5 million for the parking garage revolving fund).

Of the total amount requested, $504.5 million will be dedicated to the medical program. Key aspects of the construction budget include:

- $107.2 million for replacement and modernization activities;
- $30.5 million for nursing home care projects;
- $14.8 million for domiciliary projects;
- $44.2 million for outpatient improvements;
- $47.3 million for regional office programs; and
- $26.7 million for the National Cemetery program.

Mr. Chairman, while we support full funding of the VA's request for construction purposes, we continue to be gravely concerned that the requested amount will not meet the pressing needs of the health care system.

Also, we have noted and support the VA's proposal to convert 375 acute care hospital beds to nursing home care beds. However, in so doing, we continue to urge the VA to move swiftly in the conversion process and, when and where indicated, identify additional acute care beds that may be realistically converted to nursing home care beds. In so doing, we trust an appropriate balance will be maintained to meet the acute, intermediate and long-term health care needs of our rapidly aging veteran population.

Employment

Mr. Chairman, we believe the Administration's budget request for the Department of Labor's Veterans' Employment and Training Service (VETS) programs is inadequate. Our biggest concern is funding for the Disabled Veterans' Outreach Program (DVOP). According to Title 38, USC, Section 2003(A), 1,885 DVOP positions are authorized. The Administration is requesting $34.9 million for FY '92 and that, Mr. Chairman, is enough to fund only 1,478 positions for the period October through December, 1991. Beginning in January of 1992 and throughout the rest of Fiscal Year 1992, that number will decrease to 438.

Under current law, funding for DVOP is predicated on a formula which includes Vietnam era veterans as defined by Title 38, U.S.C., Section 2011(2)(A)&(B). On December 31, 1991, that definition expires and, therefore, would account for a large decline in these positions effective January 1, 1992. However, that does not justify the Administration's request for only 1,478 positions for October through December, 1991, when the definition is still in effect. Numerous attempts to obtain clarification from the Department of Labor have gone unanswered. They only say, "we can no longer use the definition of Vietnam era veteran," and "we are looking at contingency plans."

The Administration's Fiscal Year 1992 budget request was sent to Congress without giving any consideration to a letter sent to President Bush by Chairmen Montgomery and Cranston advising the President, in part, "When the 102nd Congress convenes in January, we plan to introduce and pursue the early enactment of legislation to extend the inclusion of Vietnam era veterans in the DVOP funding formula. We fully expect that this widely supported legislation will receive favorable, swift consideration by the two bodies."

That legislation, Mr. Chairman, took the form of H.R. 180, recently passed by the House and currently pending in the Senate. We hope the Senate will take immediate action to extend the definition and, ultimately, the number of authorized positions until December 31, 1994.

Mr. Chairman, in spite of this legislative initiative, we have no reason to believe the Administration will amend their budget request nor seek a supplemental appropriation for 1992 that would bring the DVOP funding to the authorized level.

The Administration's position on this issue makes all the more important the recent letter sent to Congressman William Natcher and others from Chairman Montgomery, Mr. Penny and Mr. Christopher Smith, seeking the support of the Appropriations Committees for the funding necessary to carry out this as well as other programs. We thank you for your foresight and immediate, decisive action on this issue.

Mr. Chairman, your letter to Mr. Natcher also points out the shortfall in funding for Local Veterans' Employment Representatives (LVER). This program is also authorized by a funding formula and, as you well know, $80.196 million is needed for LVERs. The Administration, however, has requested only $74.223 million.

Current formulas for DVOPs and LVERs are largely in response to ongoing employment problems faced by many Vietnam era veterans and disabled veterans. We did not anticipate that in early 1991 the federal government would have committed in excess of 500,000 military personnel to a war in the Middle East. Many of our current active military personnel, including reservists and National Guardsmen, will need the services of a labor exchange system provided, in part, by LVERs and DVOPs. Those services may not be available because adequate numbers of personnel will not be there to provide them. President Bush has stated emphatically that this war will not be another Vietnam. While the war may not be another Vietnam, the Administration's approach to providing employment services to returning veterans borders on being another post-Vietnam.

Mr. Chairman, the first meaningful employment legislation for Vietnam era veterans was enacted in October of 1972 -- a full eight years after the Gulf of Tonkin Resolution.

While this testimony does not specifically pertain to employment legislation for Persian Gulf veterans, positive steps must be taken soon to make sure Persian Gulf veterans receive necessary employment assistance immediately upon their return to civilian life.

Mr. Chairman, the Administration is requesting $2.052 million in their Fiscal Year 1992 budget request for transition services. As you know, however, Public Law 101-510 authorizes $9 million for this program. While Persian Gulf veterans will benefit from this initiative, transition services do not include direct job placement assistance. Rather, it is intended to assist the active duty military person in a transition from military to civilian life. Persian Gulf veterans will obtain needed information to help in their search for jobs, however, that falls short of the one-to-one assistance provided by these local employment service personnel.

Mr. Chairman, several years ago, the National Veterans' Training Institute was established in response to the need to provide consistent, adequate training to employment service personnel. Public Law 100-323 established the institute by law and is designed to provide training to both federal and state employees as well as managers and others involved in the delivery of employment services to veterans. The Administration has stated that most DVOPs and LVERs have been trained and, therefore, they are requesting no funding for NVTI. Mr. Chairman, we do not agree with their assessment. We support the continuation of NVTI and agree with your recommendation that a funding level of $2.21 million be provided for NVTI's continuation.

Legislative Proposals

The Administration's budget request contains a number of legislative proposals that will require Congressional action. The major items of interest are as follows:

- Beneficiary travel -- the beneficiary travel program would be virtually eliminated with funding decreased by $63 million. The proposal would call for the limiting of beneficiary travel benefits to veterans residing in "rural areas" defined as 50 or more miles from a VA medical center. Additionally, veterans must receive treatment for their service-connected disability(ies), or be service-connected rated at least 50 percent disabled, or meet the strict income limitations of the means test.

- Copayments -- would require that veterans rated less than 50 percent disabled for their service-connected disability(ies) to make a copayment in order to receive medical care for nonservice-connected conditions at the VA.

- The Administration again proposes to index compensation benefits to the annual change in the Consumer Price Index (CPI). If enacted, the first increase would be effective December 1, 1991, and is expected to be a 5.2 percent increase.

- Eliminate the E-1 through E-5 DIC rates over a five-year period, gradually making the E-6 level the only DIC rate. (Current DIC recipients at the E-7 or higher rate will be grandfathered.)

- Eliminate the September 30, 1992 sunset date of the OBRA provision limiting the estates of certain incompetent veterans.

- Eliminate the September 30, 1992 sunset date of the OBRA provision giving VA access to Internal Revenue Services and Social Security Administration data for the purpose of verifying the income of beneficiaries in needs-based programs and veterans receiving compensation based on unemployability.

- Eliminate the September 30, 1992 sunset date of the OBRA provision which sets a $90 pension VA cap for any veteran without spouse or child who is in a Medicaid-approved nursing home.

- Require at least 180 days of service during a period of war for disability and death pension eligibility.

- Limit Chapter 31, Vocational Rehabilitation Programs, to veterans with service-connected disabilities rated 30 percent or higher.

- Eliminate eligibility of stepchildren for Survivors' and Dependents' Educational Assistance.

- In Housing Programs, add resale losses to net value calculation and exempt Government National Mortgage Association (Ginnie Mae) from VA no-bids.

- Require a 2.5 percent fee and a 10 percent downpayment for multiple use of the loan guaranty benefit.

- Eliminate the September 30, 1991 OBRA provision increasing the user fee by .625 percent.

- Merge the Direct Loan and Loan Guaranty Revolving Funds.

- Require a 2 percent fee and a 10 percent downpayment on Manufactured Home Loans.

Mr. Chairman, the proposed legislation effecting the VA's beneficiary travel program represents yet another attempt to continue to "tinker" with the program to the obvious detriment of disabled veterans seeking health care services.

As you are well aware, Mr. Chairman, beneficiary travel benefits were severely reduced by VA during 1987. Responding to such an arbitrary reduction, Public Law 100-322 contained a number of provisions designed to accomplish an equitable administration of the beneficiary travel program.

Realizing the severe impact that would be caused by the 1987 reductions, the DAV took the initiative to launch our own transportation program.

Our effort was and continues to be directed toward supplementing the VA's existing program to ensure, as best we can, that disabled veterans are provided the means to receive the health care services they so desperately require and are entitled to.

As of November 1990, the DAV has purchased and donated 201 vans to 173 VA medical facilities conducting a DAV transportation program.

A breakdown of the transportation services provided by DAV is as follows:

	Vets Transported	Volunteer Hours	Mileage
1990 (thru 11/90)	242,685	580,183	11,553,172
1989	185,880	465,832	9,309,077
1988	101,991	279,930	5,272,635
1987	16,695	53,135	927,088
TOTALS	547,251	1,379,080	27,061,972

Mr. Chairman, the DAV opposes any further changes in the beneficiary travel program to the obvious detriment of disabled veterans.

Mr. Chairman, the DAV is in adamant opposition to the Administration proposal to continue certain copayments, as well as establish copayments that would be required to be paid by certain service-connected disabled veterans in order to receive VA medical care services.

Clearly, such a proposal has the underlying theme of restructuring the VA health care system to parallel that of the private sector.

Additionally, in our view, this proposal would have the adverse effect of forcing a large number of veterans away from the VA thus diminishing the base and patient mix of veterans able to utilize the system. The end result; a deliberate and purposeful attempt to dismantle the system to a point of ineffectiveness. Simply stated, we view this proposal as an attempt to require veterans to pay for the privilege of utilizing earned VA benefits and entitlements. The DAV vehemently opposes this proposal and would urge the Committee to soundly reject it.

Mr. Chairman, the DAV is pleased with the Administration's proposed 5.2 percent increase in VA service-connected disability and death compensation rates to become effective on December 1, 1991. We believe that, at a minimum, our nation's service-connected disabled veterans, their dependents and survivors should receive annual cost-of-living adjustments in line with the rise in the Consumer Price Index.

The DAV must at this time, however, oppose the Administration's proposal to index all future service-connected compensation increases to the Consumer Price Index, as we have a mandate from our National Convention to do so. Having stated this, Mr. Chairman, I can say that when considering the events which took place at the end of the 101st Congress causing service-connected compensation recipients not to receive a cost-of-living adjustment, this issue will, in all likelihood, cause considerable debate among the delegates to our upcoming National Convention and, quite possibly, change DAV's position on the issue of indexing future cost-of-living adjustments.

Mr. Chairman, the DAV has for a number of years now sought a change in the current rank base payment formula in the dependency and indemnity compensation (DIC) program. It is our belief that payments to survivors of service-connected disabled veterans based upon the military rank of a veteran is inherently unfair and does not reflect the true financial needs of veterans' survivors. While DAV commends the Administration's attempt to address this critical issue, we do not agree that those individuals at the lowest end of the DIC scale should wait five years before they are able to receive the standard DIC rate called for in the Administration's legislative proposal. Additionally, Mr. Chairman, we believe that due consideration must be given to the degree of a veteran's disability at the time of death.

Mr. Chairman, for the reasons previously stated herein and extensively covered in the Independent Budget, the DAV opposes the following Administration's legislative proposals:

- Elimination of the September 30, 1992 sunset date of the OBRA provision limiting the estates of certain incompetent veterans.
- Elimination of the September 30, 1992 sunset date of the OBRA provision which sets a $90 VA pension cap for any veteran without spouse or child who is in a Medicaid approved nursing home.
- Limiting Chapter 31, Vocational Rehabilitation programs, to veterans with service-connected disabilities rated 30 percent or higher.
- Requiring a 2.5 percent fee and a 10 percent down payment for multiple use of the loan guaranty benefit.
- Eliminate the September 30, 1991 OBRA provision increasing the user fee by .625 percent.
- Require a 2 percent fee and a 10 percent down payment on manufactured home loans.

Mr. Chairman, DAV has no objection to the Administration's proposal which would eliminate the September 30, 1992 sunset date of the OBRA provision giving the VA access to Internal Revenue Service and Social Security Administration data for legitimate program purposes. Likewise, we do not oppose the merger of the direct loan and loan guaranty revolving funds.

Mr. Chairman, DAV strongly opposes the Administration's proposal which would eliminate eligibility for stepchildren for dependent's educational assistance (Chapter 35, Title 38 USC) program. In our view, this is but another budget driven attempt to reduce or eliminate a long-standing VA entitlement for service-connected disabled veterans, their dependents and survivors.

Mr. Chairman, DAV supports the Administration's proposal to add the resale losses to the net value calculation in VA's home loan guaranty program, exempting the Government National Mortgage Association from VA no-bids.

Finally, DAV has no position on the Administration's proposal to require at least 180 days of service during a period of war for disability and death pension eligibility.

This concludes our statement, Mr. Chairman. I would be happy to answer any questions you may have.

STATEMENT OF

ROBERT L. JONES
AMVETS NATIONAL EXECUTIVE DIRECTOR

Before the

HOUSE COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

On

THE PRESIDENT'S PROPOSED FISCAL YEAR 1992
DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST

VS.

THE INDEPENDENT BUDGET PROPOSAL
BY VETERANS FOR VETERANS

And the

ADMINISTRATION'S PROPOSED FY 1992 BUDGET
FOR THE ASSISTANT SECRETARY FOR VETERANS EMPLOYMENT AND TRAINING

Thursday, February 21, 1991
9:30 a.m., Room 334
Cannon House Office Building

Mr. Chairman, members of the committee, AMVETS thanks you for the opportunity to testify as one of the many organizations involved in the continuing effort to achieve adequate funding for the Department of Veterans Affairs (VA). This committee is clearly aware that the budget process has not produced the dollars required to maintain the earned benefits of America's veterans; therefore, the four veterans service organizations seated here today have come once again to provide the Congress a realistic view of what is needed to provide acceptable service through an Independent Budget designed to meet funding realities.

There is, and has been, on the part of the administration, and, in particular, the Office of Management and Budget (OMB) a relunctance to face these fiscal realities and take action to revise the downward spiral of benefit delivery. The inability of VA to provide a standard of service that we can all be proud of is, unfortunately, not limited to the Veterans Health and Research Administration (VHSRA) or the Veterans Benefits Administration (VBA), but is across the board. The inability to provide the kind of service that this committee wants, this congress wants and the American people expect is plainly unattainable once again as we review the administration's proposed fiscal year 1992 budget with respect to veterans programs.

AMVETS listened closely as President Bush gave his State of the Union address to the congress and we were filled with expectation as he described our nation's commitment to the men and women who have answered duty's call in the Persian Gulf. We continued to listen for a commitment to this nation's veterans, knowing full well that these young Americans serving in the Gulf are the new veterans of tomorrow. We ask, how can you talk of war and of commitment and not utter the word "veteran." The absence of any mention of veterans or veterans' programs in the president's State of Union address causes us to reflect on this administration's claimed commitment to America's veterans. The president has repeatedly stated that the Persian Gulf war will not be another Vietnam. Our question is, does this commitment also apply to the lessons learned as a result of inadequate services and programs immediately following cessation of hostilities in Vietnam? Will the VA be staffed and funded to meet the needs of today's veterans? We reviewed an excerpt taken from The Republican Platform dated August 15, 1988. It reads:

> **Veterans**
>
> Veterans have paid the price for the freedoms we enjoy. They have earned the benefits they receive, and we will be vigilant in protecting these programs of health care, education and housing.
>
> We believe men and women veterans have earned the right to be heard at the highest levels of government. With the personal support of President Reagan, America's veterans will now have a seat in the president's cabinet.
>
> The health needs of our aging veterans are of special importance, and Republicans will not retreat from this national commitment. We encourage the new Secretary of the Veterans Department to work with the Federal Council on the Aging, and other agencies and organizations, to assure the development of new facilities and treatment programs meet the special needs of our elderly veterans.
>
> Republicans will provide necessary funding for the policy that, in all areas where there are

> no VA hospitals or long-term facilities, veterans needing medical attention for service-connected disabilities should have the option of receiving medical care within their communities with adequate funding.
>
> We must continue to address the unique readjustment problems of Vietnam veterans by continuing the store-front counseling, vocational training and job placement programs. We support veterans preference in federal employment and are vigilant about the serious problems associated with delayed stress reaction in combat veterans, particularly disabled and Vietnam veterans. An intense scientific effort must combine with respect to disabilities that may be related to exposure to ionizing radiation or herbicides.
>
> The Republican Party supports sufficient funding to maintain the integrity of the VA hospitals and medical care system and the entitlement and beneficiary system. We also support the efforts of the Department of Labor to properly meet the needs of unemployed veterans, particularly disabled and Vietnam veterans.
>
> Our commitment to America's veterans extends to the men and women of all generations.

How, with half a million new veterans on the horizon and the administration's commitment outlined above to those veterans of past wars, could anyone believe that the proposed VA FY 1992 budget will "care for him who shall have borne the battle...," but even more, who would believe that this is the president's proposed budget?

The FY 1992 White House budget announced that the administration would seek a $33.3 billion budget authority for VA programs. This should produce a $1.1 billion increase over FY 1991. The key question here is whether this increase will improve services. AMVETS thinks not!

It has become redundant to point out that year after year the administration starts the VA's budget process by inflating the total dollar figures with ill-advised legislative proposals knowing these increases amount to nothing more than robbing Peter to pay Paul.

The best example of its ability to juggle budget dollars is in the legislative proposal area of the Loan Guaranty Program. AMVETS is confident the congress would never allow such legislative initiatives to become law. Because there is no savings, the budget figures are unreal. We use the Loan Guaranty Program as an example because it is simplistic and easily identifiable. We wish all the proposals that would provide dollar increases or cost savings were as easy to identify because many of them are not in the best interest of veterans, i.e.:

- Require a 2.5 percent fee and a 10 percent down payment for multiple use of the loan guaranty benefit.
  Savings - $59 million.

- Repeal the sunset on the 1991 reconciliation fee increase. Savings - $88 million

If you've become an accomplished juggler with dollar figures, why stop there? Let's juggle FTEE, the budget authority calls for 13,140 VBA employees in FY 1992. This should--the key is should--

be an increase of 33 FTEE over FY 1991.

By VBA absorbing the function of Information Resources Management, it shows a net increase of some 333 employees through transfer. Another 307 employees will be dedicated to implementing the deficit reduction provisions of OBRA and 50 FTEE for the Transition Assistance Program. Using the new math or simply figuring it out the old fashioned way, VBA will suffer a significant loss of those employees who process the claims and provide direct service to veterans. One estimate puts that loss at 267.

HEALTH CARE

The president's FY 1992 budget contains approximately $976 million in increases for the VA's medical programs. This increase, however, is sufficient only to offset the costs of inflation, provide for increased payroll and comply with nationwide standards concerning resident work hours. (We estimate 85 to 90 percent of the increase will be eaten up by these costs.)

We are pleased that there is movement to convert a number of hospital beds to nursing home-care beds, but the proposal falls far short of the real need. AMVETS requests that the committee review the requirements set forth in this area in the Independent Budget.

The administration's budget proposes $85 million for the state extended-care facility program--which is $15 million more than FY 1991 and double the amount in FY 1990. This move to shift more of the responsibilities to the states for long-term care is consistent with the overall cost shifting taking place at the federal level. The program will, as a positive note, make more long-term care beds available to veterans.

The proposal to add 15 geriatric evaluation management units to the medical care system is a step in the right direction. The cost of these programs, however, is minimal and every medical center should have this type unit to accommodate the majority of those veterans who currently access VA health care.

It would appear that at this time of national concern for those men and women currently facing potential medical traumas brought on by war, that additional funding for medical research is in order. Common sense should dictate an increase, not a decrease in VA medical and prosthetic research activities of the VA. It's time to put a stop to the continued erosion of a program that has produced numerous medical breakthroughs which have benefited not just veterans, but all mankind.

Although the administration has proposed $144 million for new equipment, this amount pales in contrast to the equipment needs of the medical-care system estimated at some $1 billion dollars.

This budget will do nothing to lessen waiting times for clinical care nor provide ample inventories of medications and supplies, but the most devastating thing is simply the overall expansion of denied care.

VETERANS BENEFITS

AMVETS is unable to comprehend the administration's indifference to claim processing delays, case backlogs, understaffed vocational rehabilitation units and unanswered phones. It is believed that this budget will produce some 250 fewer VBA employees to process claims with 27 less employees at the Board of Veterans Appeals (BVA). Let's take a look at the claims process to include BVA.

When a veteran files a claim and the claim process includes a review at BVA, everyone knows that the veteran is expected to wait patiently in excess of one year for a final decision. Based on the first quarter, FY 1991 BVA report, we find that BVA made 11,071 total decisions. In 2,955 of those cases, the decision was to remand the case to the office of original jurisdiction, meaning the veteran was denied due process or the claim was improperly developed, etc. The bottom line is that 26.7 percent of the cases decided by BVA in the first quarter of FY 1991 will now take some two years before the veteran is provided with a decision. Further, we are advised that the number of remanded cases will increase now that the Court of Veterans Appeals is in place.

It should also be noted that the court has, and will continue to cause, an increased workload in the General Counsel's office which is also projected to lose 30 FTEE.

By looking at something as fundamental as processing a claim for benefits, you have an idea of just how inadequate the entire delivery system has become.

Mr. Chairman and members of this committee, how long must we hear that "Automated Data Processing Initiatives," Modernization" and "Other Management Improvements" are all that is required to reduce the backlogs, improve timeliness and provide quality care and services?

These initiatives are important and must be part of any long-range planning; however, the system must be improved to a point where there is an even chance that modernization can prevail. In the interim, however, we must provide an acceptable standard of service to the veteran. The administration's FY 1992 budget for DVA will not allow this to happen. What, then, is the alternative?

As you are aware, AMVETS, the Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars have once again cooperated to address the needs of America's veterans -

- needs based on the moral as well as the legal obligations that this nation has to those men and women who answered duty's call then and now. For the fifth consecutive year we have produced an Independent Budget by veterans for veterans. With the knowledge that each member of this committee has a copy of that proposed budget, I wish to point out that AMVETS supports fully the principles and guidelines used in its formulation. We further view the Independent Budget in toto as a legitimate alternative to the administration's proposed FY 1992 budget. You will find those areas of concern mentioned herein explained and analyzed in great detail together with every aspect of the overall budget.

NATIONAL CEMETERY SYSTEM

The administration's appropriation request of $57.3 million for the National Cemetery System is $14.6 million short of the projected need outlined in the Independent Budget. In the FY 1991 budget process this committee recognized the need for additional funding in this program area and consistent with the Independent Budget recommendations, both the House and Senate Veterans Affairs Committees recommended significant increases over VA's appropriations requests. (The Senate recommended an increase of $14.4 million and the House recommended a $15 million increase.) The House Veterans Affairs Committee's breakdown of the recommended increases was as follows:

Personal services -- 100 FTEEs	$3 million
Replacement equipment backlog	$7 million
Maintenance and repair projects deferred	$1.3 million
Supplies and materials shortfall	$1.2 million
Utilities (water)	$800 thousand
Equipment and supplies for activation of new cemeteries	$600 thousand
Additional equipment for increased workloads	$1.1 million

TOTAL	$15 million

Thus, a total of $69.8 million (VA's request of $54.8 million plus $15 million) was needed to enable the efficiently-managed NCS to restore and maintain the cemetery system to adequate standards. After the appropriations dust settled, however, NCS received $53.5 million.

The congress must act to preserve our national cemeteries, which are akin to our national parks, and therefore should be considered a national treasure.

VETERANS EMPLOYMENT AND TRAINING

Mr. Chairman, AMVETS is distressed that at a time when we have more than 500,000 servicemen and women in the field, the administration's budget for the Office of the Assistant Secretary for Veterans Employment and Training (OASVET) for fiscal year 1992 reflects a substantial reduction. Although we have heard many times that the Persian Gulf war will not be another Vietnam, it would appear to us that little thought, much like during Vietnam, has been given to the post-conflict era. One has but to briefly review the OASVET budget to see a lack of foresight. Disabled veteran outreach program specialists' program funding is reduced by more than 45 percent. The homeless veterans program has been deleted as has the funding for the National Veterans Training Institute and JTPA Title IV.C. is being further reduced. AMVETS has reason to believe that the Department of Defense has deemphasized transition assistance planning and that the administration will seek to repeal that provision of the Defense Authorization Act dealing with separation programs. Veterans continue to be denied equitable unemployment benefits as compared to nonveterans. We continue to hear from state directors that inadequate travel funds, cumbersome administrative demands and internal Department of Labor imposed priorities substantially detract from their ability to perform mandated tasks.

We recognize that current veterans' employment and training statues are based on the provision of priority services to veterans of the Vietnam era and that there are cohorts of these veterans who continue to need special attention. It is time to take a flexible approach that recognizes the diversity among veteran cohorts most in need. The nation must not only reaffirm its commitment to veterans of our armed forces but also pursue veterans preference in all federally-funded programs. It is time to remove the impediments to economic security for veterans and their families and to encourage cooperative efforts among local, state and federal governments and the private sectors in developing a preferential program of services to veterans. The Department of Labor must assume a leadership role in coordinating the delivery of preferential service to veterans in all federally-funded employment programs which affect the private sector. Now is the time to establish a clearly defined national veterans employment and training policy that provides preference in the following order: special disabled veterans, disabled veterans, conflict veterans, other veterans and other eligibles (active Reserve and National Guard members). Mandated responsibilities, staffing formulas and targeted populations must be modernized. OASVET must take a leadership role in redesigning the dedicated veterans employment delivery mechanism.

The erosion of veterans employment programs and services as reflected in the administration's fiscal year 1992 budget must be reversed, existing legislation modernized to fulfill current needs and a clearly defined, enforceable national veterans' employment policy established.

STATEMENT OF
VICTOR S. MCCOY, SR., NATIONAL PRESIDENT
PARALYZED VETERANS OF AMERICA
BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
ADMINISTRATION'S PROPOSED FISCAL YEAR 1992 BUDGET
FOR THE DEPARTMENT OF VETERANS AFFAIRS
AND
THE INDEPENDENT BUDGET FOR VETERANS AFFAIRS
FOR FISCAL YEAR 1992

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February 21, 1991

Mr. Chairman and Members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the Administration's proposed fiscal year 1992 budget for the Department of Veterans Affairs (VA). As you know, the Independent Budget, co-authored by American Veterans of World War II, Korea and Vietnam, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars, provides our detailed assessment of funding requirements we believe are necessary to properly meet the needs of all eligible veterans for FY 1992. We are pleased to present those recommendations to you today.

This is the fifth year that we have formulated and presented to the Congress this in-depth analysis of veteran need and Independent Budget recommendations. Our document reviews every aspect of funding for VA health care, medical research and benefit delivery systems administered by the Department. Because the Independent Budget does not rely on arbitrary restraints and limitations imposed by the federal budget process, we have attempted to show what is actually needed - rather than what has been provided - to support all VA programs.

The evolution of the Independent Budget has incorporated a fiscally prudent approach to addressing many of the budgetary shortfalls experienced by VA over the past five years. We sincerely appreciate this Committee's recognition of the financial problems facing VA and the fact that you have been receptive to many of our budget proposals since the inception of the Independent Budget. Historically, your recommendations to the Budget Committee have demonstrated a true understanding and appreciation for realistic funding levels needed to support the legislation which you have passed in behalf of veterans and their families.

One year ago we came before you with an Independent Budget entitled "The Price of Peace". As the spirit of harmony and cooperation throughout the world was tearing down the walls and barbed wire that separated us from our cold-war enemies, we looked forward to the possibility of a "peace dividend" - a dividend we strongly believed our nation's veterans should rightfully share. The men and women who stood guard on the front lines of freedom and democracy were, after all, greatly responsible for securing the reductions of tensions in the world. The continuing cost of war - so often referred to as our nation's obligation to care for those who have served in our Armed forces - had appropriately become the "price of peace."

The war in the Middle East has caused all of us to realize just how fragile peace is. Although we spoke last year of an obligation to correct budget priorities for veterans, our recommendations were based in part on an underlying concern that, perhaps, there were some who had forgotten the sacrifices made by veterans of our armed forces to preserve the freedoms we enjoy. Events which have occurred since August 2, 1990, will certainly act as a clear reminder. Although it is unknown to what degree the war will ultimately affect VA's ability to provide quality health care and benefit services to veterans, our nation's obligation to those who have served - whether in World War I, World War II, Korea, Vietnam, Granada, Panama, the Middle East or anywhere else US servicemen and women have been called to duty -

must represent the best we, as a nation, can offer.

Today, thousands of young Americans are being asked to match the sacrifices of the millions of veterans who served in defense of this nation before them. Now, more than ever, we believe it is essential that our government maintain the quality and quantity of veterans benefits and services necessary to uphold our nation's commitment to veterans and their families. Quality health care, research, rehabilitation and timely benefits are not too much to ask for those who have served.

The Independent Budget depicts the status of veterans programs based on projections of veteran demand reviewed each year for the past five years. In addition to itemizing the resource levels required to meet those projections in terms of today's dollars, the Independent Budget also identifies programs, services and resources needed to help VA meet future needs of the veteran population. It is not our purpose in this testimony today to reiterate all of the concerns and recommendations expressed in the Independent Budget. Rather, we will highlight the areas we believe are most deserving of your attention and comment on the probable effects of the Administration's budget for FY 1992.

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VA MEDICAL PROGRAMS

We wish to begin by discussing Operation Desert Storm and the potential effect the Middle East War could have on the Department of Veterans Affairs. As you know, the Department of Veterans Affairs and Department of Defense have implemented the VA/DoD Contingency Hospital System. For the first time since Public Law 97-174 was passed in 1982, VA's 172 hospitals have been fully alerted to serve as the primary back-up to DoD's considerably smaller hospital system. The nation's largest health-care system is ready, according to VA, to accept military casualties. Eighty

VA hospitals have been designated as "primary hospitals" and would receive patients directly from the battlefield or from a DOD facility. VA has further designated additional medical centers as "secondary centers" to receive current eligible veterans transferred from primary facilities. With authorization to contract for community beds and a mechanism in place for VA to request supplemental funding in the event of a surge in patient workload, it would appear - on paper - that VA is ready. We have serious concerns however, that in reality, VA's health care system will be overwhelmed by large numbers of casualties from the Middle East.

The Persian Gulf crisis coincides with a VA health care funding crisis of enormous dimensions. Projections of VA funding requirements in the Independent Budget indicate that VA presently does not have the resources to provide the same level of care the Department provided to veterans in 1988. As a result, VA has been forced to restrict the provision of certain services to veterans and to reallocate resources from equipment, supplies, and other health care support services already in short supply.

We have little doubt that the Congress will appropriate necessary funds to accommodate health care for any casualties from the Middle East - and that is as it should be. However, because PL 97-174 provides active duty military personnel with a higher priority for VA medical services than all others except service-connected veterans, it is clear that some categories of veterans will be forced to obtain their health care elsewhere. Further, although VA and DoD will share the cost of health care while an individual is on active duty, VA alone will shoulder the long term financial responsibility for health care rehabilitation implementation.

VA has indicated that spinal cord injury treatment is a medical specialty to be highlighted in contingency plans to support DoD health care. Because of the intricate nature of spinal cord injury itself, a high degree of expertise involving the multidisciplinary coordination of numerous medical specialties is necessary to provide quality health care to paralyzed people. If spinal cord injured veterans need to be transferred from existing VA Spinal Cord Injury Centers to make room for Persian Gulf casualties, does VA have an additional contingency plan to ensure that those veterans can receive adequate treatment in the private sector relating to this complex medical specialty? Unfortunately, the vast majority of patients requiring medical specialties like SCI-care have no alternative sources since most private sector hospitals do not have programs that compare in quality and scope to VA services.

Further, as VA physicians and nurses who are reservists are called up to serve - especially those with expertise in specialized fields - who will fill the void? In an interview with Dr. Joseph E. Binard, VA Director of Spinal Cord Injury Services, published in the February 1991 issue of Paraplegia News magazine, Dr. Binard said ...

> "Our main problem is the lack of SCI doctors and nurses. Right now we are working with as few as we can. If we were suddenly to have an influx of patients, we would require additional staff support."

In answer to the question "Is your service compromised by this?", Dr. Binard answered, ...

> "Yes - we need more help. Let us not forget that we are one of the only services in the VA system that still receives military personnel on active duty. The military stabilizes SCI patients and then sends them to us while they are still on active duty."

As of last month, VA had lost 1,923 of its staff to the military reserves including 194 MDs and 734 RNs. Twenty-two SCI personnel have been called to active duty including four physicians and seven registered nurses. We are very concerned about VA's ability to provide quality care for eligible veterans and Gulf casualties alike.

Currently, VA is utilizing temporary physicians and nurses while working with State Boards of Nursing and State Medical Societies to prepare rosters of MDs and RNs available to volunteer. The Department is also utilizing the assistance of civilian physicians through previously established agreements with medical schools. While VA activates these plans to replace personnel lost to the reserves, PVA stresses the need to maintain, within VA, physicians and nurses who are qualified to care for spinal cord injured veterans.

PVA strongly supports the intent of PL 97-174 to respond to the health care needs of our active duty men and women. In so doing, we urge the Administration and the Congress not to forget those, from other times, whose admittance priorities have been bumped down a notch -- those veterans who are homeless, disadvantaged, elderly -- those who require special medical care such as SCI care -- those who have no where else to turn. It is critical that the Congress plan now for potential casualties from the Middle East. If the Middle East War causes a surge in the number of patients at VA Medical Centers, we urge the Congress to pass -- as quickly as possible -- a supplemental appropriation to ensure quality health care for every eligible VA patient.

VA's Funding Crisis - A Brief History

Mr. Chairman, since the first Independent Budget was prepared for Fiscal Year 1988, we have come before you each year to tell you that, from our perspective, VA's health care system has been in a state of crisis -- a viewpoint we know you and the Members of this Committee have shared. The disastrous budget request for FY 1989 - nearly $640 million short of anticipated needs by VA's own admission - created absolute chaos in the system. Since that time, the Office of Management and Budget (OMB) has continued their practice of budgeting with significant shortfalls carried over from one year to the next. OMB has abandoned accounting for "current services" and instead, takes a budget "snapshot" each year without any regard to cumulative deficits in available services that have accrued from an eroded resource base.

Despite the Administration's generous $1 billion increase in the proposal for FY 1991, we still have a long way to go. Fortunately, the Congress, through the help of this Committee, has gone a long way in greatly improving overall funding levels. During the past four years, the Congress has added approximately $2 billion over the Administration's recommended budgets. Without this understanding and assistance, VA's situation would be considerably worse.

Unfortunately, due to the severe damage already inflicted each year by OMB on VA's funding levels, coupled with increasing veteran health care demand and skyrocketing medical costs, the appropriated amounts have simply not been sufficient to adequately provides an acceptable level of quality medical care services and benefit delivery.

The Impact of Budget Shortfalls -- Where VA Stands Today

Past Independent Budgets have included statements of concern regarding deteriorating VA medical care quality. Inadequate resources have resulted in shortages of staff, supplies, and equipment, delays in prosthetic services, and outpatient clinic appointments, and rationing of nursing home care. Annual funding shortfalls are particularly destructive because they are applied to a chronically eroding resource base.

Evidence to substantiate these conclusions was obtained through telephone surveys in connection with the construction of the FY 1990 and 1991 Independent Budgets. Another survey was conducted in the course of developing the Independent Budget for FY 1992. It revealed a continuing story of hospital administrators absorbing budget shortfalls by postponing need equipment replacement, eliminating programs, and rationing care. These forced practices do not translate into quality health care delivery.

We have, however, ample evidence that VA Medical Center (VAMC) staffs are conscientiously doing their best with the material shortages at hand. We think it deceptive and destructive for television news shows to focus on isolated perceptions of patient neglect, indicting the entire system in the process. Staff insensitivities undoubtedly do occur - and should be corrected immediately. The thousands of dedicated employees who are very caring in their service to veteran patients, however, should be commended. On behalf of all of PVA's members, we express our appreciation for their devoted service.

During late November 1990, the Independent Budget staff conducted its third telephone survey, contacting representative VAMCs across the country. Survey questions were again designed to elicit information on any continuing impact of budget shortfalls in FY 1990, along with expectations for the current fiscal year.

The similarity of facility reports was striking. Findings are presented in a summary fashion and without attribution:

- VAMCs again absorbed shortfalls ranging from one million to four million dollars per facility in FY 1990. To meet the medical care need, centers redirected funds originally intended for equipment purchase, contract medical service (especially nursing home care and fee-basis ambulatory care), personnel salaries, and building maintenance.

- Most hospitals still report backlogs of needed but unpurchased equipment, ranging in total value from one million to eight million dollars per facility. This equipment backlog has made it difficult in many instances to maintain state-of-the-art patient care. One chief of staff estimated that more than $35 million worth of heavily used equipment would reach obsolescence during the next five years, a situation which he believed to be not uncommon throughout the VA health care system.

- Outpatient clinic appointment waiting times of more than three to four months were widely reported. Certain specialty clinics in some VAMCs had appointment backlogs of up to nine months. Consistently, the explanations revolved around staff shortages, aggravated in some instances by call-up of military reserve physicians and nurses. Some directors also cited insufficient equipment, such as computerized axial tomography scanners, to meet both the inpatient and outpatient workloads.

- Nurse vacancies existed in every facility contacted. Most hospitals had 20 to 50 unfilled positions, involving especially intensive care units. Some directors reported their inability to compete with salaries in surrounding communities, in spite of special pay incentives.

- VAMCs have similar difficulties recruiting certain physician specialist, for example, anesthesiologists, radiologists, and orthopedists. Delay in Congressional authority for VA physician pay increases aggravates this situation. Staff morale is low in all hospitals as a result of employee's awareness that expected budget shortfalls will result in further reduction of FTEEs and services.

- Medical centers are concerned that the centrally managed prosthetic funds at VA Central Office will not meet systemwide needs because of projected 1991 budget shortfall.

- Most hospitals report long delays in scheduling elective surgery. One VAMC has a waiting list of 280 herniorrhaphies, averaging more thah six months delay. Some survey respondents reported routine disapproval for any high-cost elective surgical procedures.

- One large tertiary care hospital reported increasing inability to accept transfer patients from referring regional VA facilities. The latter, in turn, are resorting to use of high-cost, fee-based, private community medical facilities.

- Because of inadequate activation funding, newly constructed additions at several hospitals have been unable to open all beds.

- Recent attention to military contingency plans in connection with operation Desert Storm has raised concerns about VA's ability to provide backup to the Department of Defense.

- Many of those surveyed reported a growing demand for long-term care, and the impossibility of meeting that demand with available resources.

The above findings were similar to those conducted by the House Veterans Affairs Committee (HVAC) in its August 1990 questionnaire to which 160 VAMCs responded. Aggregate numbers from that survey indicated that the percentage of operating beds that are closed has increased from 25% to 32% during 1990. Approximately 20,000 beds are no longer in use. The HVAC survey also found a marked decrease in nursing home census and prolonged clinic waiting times.

Independent Budget survey findings indicate that many deficiencies in the VA health care system which were the subject of special hearings before the Congressional Veterans Affairs Committees in the Fall of 1988, remain uncorrected. Further, the results of the survey suggest that more veterans' health care needs are going unmet as demand is further suppressed by resource constraints.

Outlook for VA Health Care Funding for FY 1991 - PL 101-507 VA-HUD-Independent Agencies

In our development of a needs-based budget proposal for FY 1992, we factored in funds appropriated for VA health care each year since 1988, the last fiscal year that budget appropriations did not severely constrain VA workload. As a result, although PL 101-507 appropriated $12.31 billion for VA medical care in FY 1991 (compared to the Administration's budget recommendation of $12.227 billion), the Independent Budget's current services level for FY 1991 stands at $12,919,600,000.

We arrived at this FY 1991 budget baseline by adding $405 million in payroll items, $210 million in inflation, and $210 million in other adjustments and facility activation costs to the $12.1 billion FY 1990 appropriation. A general explanation of these funding levels follows. A detailed explanation can be found in the "Medical Programs" section of the Independent Budget.

Payroll and Inflation

Medical care is labor intensive; personnel costs consume approximately sixty percent of the FY 1991 Medical Care budget. If funds are not sufficient to support VA personnel costs, then VA must utilize funds from other discretionary medical care accounts. When these discretionary accounts are exhausted, workload must be reduced by turning patients away, extending the time between outpatient visits and delaying elective inpatient procedures.

Non-federal physicians' and nurses' pay has increased more rapidly than general inflation. Congress has recognized that VA cannot retain its staff of qualified health professionals at pay levels significantly lower than those available in the private sector.

Activation of Facilities

VA incurs activation costs when new construction or renovation is completed and new facilities are brought "on-line". Activations of facilities that will be completed in FY 1992 should require approximately $243 million. However, dollars allocated for previous years' activations have been inadequate. The money was not available because authors of the President's budget assumed that some projects would not be completed on time and, therefore, did not provide activation funds. The OMB exaggerated this "slippage factor", and as a result, expensive facilities stood empty at tremendous investment cost to the government and of no use to veterans.

Using the above payroll, inflation, and facility activation costs for FY 1991, we established the $12.9 billion figure as a baseline from which to build our FY 1992 budget recommendations. We remain committed to the principal that VA should maintain a system that can deliver first-rate health care to all entitled veterans. The basis of current services must be adequate to meet veterans' needs. The following statistics show how the gap between the IB current service levels and the actual appropriations over the years have grown:

	IB Current Service	Appropriation*	Shortfall
FY88	$10,158,000,000	$10,126,538,000	$31,462,000
FY89	$10,952,500,000	$10,887,671,000	$64,829,000
FY90	$12,094,200,000	$11,436,306,000	$657,894,000
FY91	$12,919,600,000	$12,310,490,000	$609,110,000
FY92	$14,020,600,000	$13,287,096,000	$733,504,000

* Includes Supplemental Appropriations

The IB funding levels represent the necessary appropriations upon which each year's subsequent budget proposal should have been based. Clearly, OMB budget snapshots taken each year without the benefit of a clearly defined benchmark, have left VA - and all disabled veterans - in a most difficult position.

Administration's FY 1992 Budget Proposal - Health Care

For the second year in a row, PVA believes the President has recognized the seriousness of VA's funding shortfalls from earlier years. With a total budget authority of $33.2 billion for FY 1992, including an increase of $974 million for medical care programs, the Administration has slowed the decline of VA's health care system.

Unfortunately, VA's budget continues to fall far short of compensating for past shortfalls, maintaining quality care, replacing aging medical equipment, and meeting anticipated demands for the coming year. It must be understood that veterans health care services, in comparison with all other federal health care entities, have not received their fair share of federal dollars to keep up with soaring medical inflation rates over these last five critical years.

The Administration's proposed $13.3 billion medical care budget authority for FY 1992 provides almost a billion dollars more than the actually appropriated for FY 1991. Increases in personnel for an FY 1992 proposed total of 196,114 employees, is also an indication that the Administration recognizes VA must do something about the severe staffing shortages which currently exist in VA hospitals around the country. There is no question that these new employees will be of great benefit to the VA health care system. On the surface, the proposed funding and staffing levels are encouraging. We appreciate efforts made by Secretary Derwinski and Deputy Secretary Principi throughout the OMB negotiations process in formulating the FY 1992 budget proposal.

However, analysis of the budget reveals that of the $974 increase in the medical care account, approximately $581 million will go toward salaries, retirement benefits and other personnel costs, another $279 million will be spent on inflation, and program changes will consume an additional $144 million. After a decrease in facility activation money is factored in, very little, if any, will remain for actual improvements in direct "hands-on" patient care. The ever-increasing need for VA geriatric care alone will continue to put VA in a deeper and deeper hole. The majority of additional FTEE will be used for activation of facilities and staffing other facilities coming back on line. Again, this will offer little relief to existing medical care staff beset by severe shortages of personnel.

Medical and Prosthetics Research

For the members of PVA, the Medical and Prosthetics Research account represents one of the most important investments of VA funds. Hit hard by inconsistent and insufficient funding over the past five years, the program has been beset with disruptive budget and personnel fluctuations. Research needs stability and continuity. Researchers must be able to count on appropriate funding levels down the road to maintain on-going projects and to begin new ones.

The Administration has proposed a budget of $216,795,000 for this important account with a decrease of 348 personnel for FY 1992. This level of funding and staffing, approximately $64 million below that recommended by the Independent Budget, will further erode VA's research capabilities. Further, the Administration has not included the $20 million transfer from DoD which had been recommended in prior budget proposals. We urge the Committee to reject the Administration's budget proposal for this account and, instead provide the $280 million necessary to maintain a research program which is second to none. Please keep in mind that many of the prosthetic devices which are in use today to help individuals overcome wartime disabilities would not have been developed if it were not for the Department of Veterans Affairs.

Nursing Homes and Long Term Care

PVA is pleased that the Administration is taking positive steps in dealing with the aging veteran population by converting existing hospital space to nursing home use. VA is planning to convert 375 such beds in 1992 and is evaluating the conversion of up to 5000 beds by 1997. For institutional and non-institutional long term care, the Administration has proposed a budget of $1.594 billion. Total long term care beds - including the converted nursing home beds and state grant beds - are anticipated to number 1,863 in 1992.

Although we welcome this expansion of nursing and long term care beds, we strongly recommend an accelerated approach to the rapidly increasing demand for nursing and long term care alternative. As stated in the Independent Budget, we believe the VA operated nursing home census should be increased to 16,180 in 1992. Community and state nursing homes must also increase their veterans census at an accelerated pace.

AIDS

The AIDS Program in Veterans Health Service and Research Administration (VHSRA) has become the largest single source of direct health care services available for treating AIDS. VA estimates that the Department will be spending approximately $325.3 million for the program in FY 1992, a $75 million increase over last fiscal year. Although the cost of this expensive program is earmarked to cover the expenses of treating eligible AIDS patients, the Administration has not allocated additional funds to VA's medical care account to offset the cost of this increasing patient workload.

Last year the Independent Budget recommended incrementing the FY 1990 current services level by $60 million to accomodate the needs of AIDS infected patients. This year, we recommend adding $52.5 million to the FY 1991 current services budget to reach total required levels in FY 1992.

PTSD

The importance of an expanded and adequately funded PTSD program has become increasingly apparent. However, in 1991, there will be only 20 VA inpatient treatment units, 45 PTSD clinical teams, and 196 vet centers designated to provide this service. The Independent Budget strongly supports the expansion of services for the treatment of PTSD by recommending 20 new clinical teams and four new inpatient units for 1992. Efforts must be made to target these eligible veterans and address their specific needs.

The Administration's Proposed Legislative Health Care Initiatives for FY 1992

In an attempt to expand the already inequitable copayments contained in OBRA 1990, the Administration proposes to require copayments for higher income service-connected veterans rated less than 50 percent for nonservice-connected conditions. Mr. Chairman, this provision simply further erodes the commitment made by a grateful nation to those who have sacrificed - those who were disabled in the line of active duty. We strongly oppose this initiative on philosophical grounds. When it comes to health care, service-disabled veterans should not be required to balance the books for deficit reduction.

We strongly urge this Committee to also reject the Administration's proposal to severely limit the beneficiary travel program. The proposal, which limits beneficiary travel to veterans living 50 or more miles from a VA facility, will impose significant hardship on many veterans. In addition to the 50 mile limitation, a veteran must be receiving care for a service-connected condition, be rated at least fifty percent service-connected for any condition, or have income less than the Category A level. Coupled with the copayments imposed by OBRA 1990, a veteran falling into the "discretionary workload" category who lives 30 or 40 miles from the nearest VA facility will be forced to shoulder an unfair portion of the deficit reduction problem. Once again, in the case of veterans who have disabilities resulting from active duty, we oppose any further restrictions to VA's beneficiary travel program. This represents just one more example of entitlement changes, restrictions, and imposed user fees designed to drive veterans from the VA system and the health care they need.

Independent Budget Recommendations FY 1992 - Health Care

PVA and the authors of the Independent Budget have established a fiscal year 1992 current services level of $14,020,600,000 for VA medical care. Our recommendation for FY 1992 - which includes various provisions to strengthen VA's medical programs - is $14,889,850,000.

Category A Entitlement

The VA health care system was once distinguished for offering patients a comprehensive, coordinated continuum of care. Because of budget shortfalls and confusing entitlement rules, many Category A veterans, who have clear entitlement to inpatient care according to Title 38 of the U.S. Code, are not entitled to outpatient care.

VA health care officials indicate that most VA medical centers are reducing access to ambulatory care through restrictive use of the "obviate the need" clause in Title 38. VAMCs make this dollar-driven decision irrespective of physicians' professional judgments. Many facilities, because of inadequate resources, give care to medically indigent non-service-connected patients only in emergencies.

Basing decisions to provide or deny medical care on a financially motivated interpretation of the "obviate the need" clause leads to mismanagement of chronic illnesses. It is bad medicine and bad economics to turn away patients who need outpatient care on the grounds that their current condition is not sufficiently severe to require hospitalization. It invites acute, serious and costly complications. It also contradicts the current universal emphasis on non-institutional care and preventive medicine. Ironically, whereas the Category A, medically indigent, non-service connected veteran still has clear entitlement to all inpatient treatment, he has recently lost access to many procedures now shifted, under cost containment pressure, to an ambulatory setting.

The VSO's strongly reaffirm our support for legislation which would provide outpatient, nursing and extended care services for Category A veterans.

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The VSOs have constructed the Independent Budget on the premise that strategy should drive operations. The primary mission of the Veterans Health Services and Research Administration (VHSRA) is to provide high quality health care to entitled veterans. Adequate resources should be allocated to achieve that objective. Past Independent Budgets have pursued that premise relying on a set of strategic principles for budget formulation. Although our recommended programs and budgets have not been entirely implemented, we still consider the recommendations sound. We also maintain that, had the VSOs' recommended funding targets been achieved, the current VA health care crisis might have been averted.

The VSOs have reassessed their strategy for the VA health care system, and have reaffirmed that changes in the system are essential. Selected system changes that are in veterans' best interest can take place without cost or with minimal cost. For example, activating a Geriatric Evaluation and Management (GEM) program in each medical center would save significant resources by enabling timely, comprehensive assessment of elderly patients' medical care requirements. These GEM programs are needed to efficiently accommodate older veterans' rapidly increasing use of the system.

The apparent lack of discipline in the management of the health care system indicates a need for stronger central control. VA should not allow program or activity expansion under any circumstances without central approval in accord with a systemwide operating and strategic plan. VA should review all programs that were implemented as a result of the competitive incentives built into the now-abandoned Resource Allocation Model (RAM). In addition, VA should review and reaffirm every medical center's missions and workload targets, monitor their programs and workload levels, eliminate duplicate services in proximate sites, and distribute resources to meet established workload targets. VA must take drastic action to address the potentially devastating budget problems that its health care system now faces.

To meet veterans' needs more efficiently, VA should shift current resources as needed to achieve recommended program and workload targets. VHSRA should set realistic goals and objectives for the next five years, and establish a centrally controlled mechanism for achieving those objectives. Sound planning today will strengthen tomorrow's VA health care system.

Meeting the Needs of Aging Veterans

Beginning in the 1980s, most veterans of World War II and the Korean War eras -- the largest groups of veterans -- turned 65. In 1980, there were three million veterans age 65 or older and in 1990, seven million. By the mid-1990s, one-third of all veterans will be older than 65, and by the year 2000, almost nine million veterans will have reached this age. After 2000, the number of veterans older than 65 will decrease. The unknown component, of course, is the potentially enormous impact today's younger servicemen and women of Operation Desert Storm will have on the long-range needs of aging veterans.

As people age -- particularly as they age beyond 65 -- they require progressively more health care, and their need for long-term care grows even more rapidly than their need for acute care. The statistics on veterans' actual use of VA care underscore the point. Veterans ages 65 to 74 use VA hospital care twice as often as those younger than 55. Those older than 75 use this care 75 percent more frequently than those in the 55-64 age group.

Although this increased use of VA inpatient hospital care with advancing age is dramatic, it is small compared to the increased use of nursing home care. Men ages 85 and older use VA nursing home care almost 30 times as often as men ages 55 to 64.

The necessity of meeting aging veterans' rapidly growing and changing needs is fundamental to this Independent Budget's medical care appropriation recommendations.

Multi-Level Long-Term Care Facilities

VA should move to the vanguard of geriatric and long-term care. World War II veterans have reached an average age where their health calls for more sustaining care. In the last decades of life, healing takes longer, and in the last years of life, the aim of medicine must shift from curing to comforting. Our veterans are getting old now, but their average age is only about fifteen years older than that of the general population. In the 1990s, VA health care will face the crisis that society as a whole will face in the first decade of the twenty-first century. It is right that VA lead the nation in the care of the aged. Leadership in long-term care is arguably the best use of the tremendous resources that VA's nationwide system of hospitals and clinics represents. Expansion into long-term care will best assist the veteran today and prepare the country for the future.

VA is in an excellent position to develop a prototype dedicated geriatric and long-term care center. We suggest that each VA medical region select one secondary care hospital, near a tertiary referral VA medical center, and through total conversion of its beds and mission, dedicate that secondary care hospital to long-term care. Each such center would offer a nursing home, a geriatric evaluation and management program, ambulatory clinics, an adult day care center, a home care team, a respite program and a hospice program. The long-term care center staff should include appropriate numbers of geriatricians, internists, physiatrists, psychologists, and social workers. There should be ample facilities for functional rehabilitation, physiotherapy and occupational and recreational therapy. The center should enter into cooperative arrangements with other community-based long-term car facilities and programs.

The VSOs strongly believe that expanding nursing home capacity is critical to ensuring appropriate quality care for veterans. Since 1987, the Independent Budget has called for VA to convert under-utilized acute care beds to nursing home beds, but VA has made limited progress in this area. We are hopeful that the Administration's proposal for FY 1992 is indicative of improvements to come. The Administration's FY 1990 budget called for the conversion of 149 beds; in FY 1991, 79 beds was the goal. Although we are pleased that the Administration has proposed the conversion of 375 beds for FY 1992, VA still has a long way to go to stem the growing demand for these beds. Budget constraints have been partially responsible. Strapped for medical care dollars, VA facility directors have been unwilling to invest in converting hospital beds to nursing home beds, even though substantial savings would result of the system.

VA hospital directors are aware that their teaching hospital affiliations and their community positions will be threatened if they are perceived as "old soldiers homes." Our November 1990 survey of VA hospitals showed that only about 20 percent of VA medical center directors would convert beds, even if funds were available for needed construction and staffing. Now that the Administration appears to be willing to address the need for converted nursing home and long term care beds, we encourage hospital directors to support this effort.

For the long-term, we propose that the system add 480 VA nursing home beds annually, by completing four new 120-bed nursing homes each year and through conversions. Work on these new nursing homes must start now. Our FY 1992 Construction Programs budget proposes appropriations for four nursing homes. The construction program VA nursing home expansion requires is further described in the "Construction Programs" section below.

We recommend increasing the VA-operated nursing home census to 16,180 in 1992. To meet the overall nursing home care needs, we also recommend that the community nursing home average daily census be expanded to approximately 14,600 in 1992. In addition, we propose an increase in state veterans homes' average daily census to 11,220 in 1992.

Treatment of Spinal Cord Injured Veterans

Spinal cord injury (SCI) is an example of catastrophic illness dependent upon not only multi-specialty medical care, but drawing heavily on social and economic resources as well. VA, the creator of SCI Treatment Centers following World War II, has been in the vanguard of providing life saving and life sustaining support for SCI victims.

Under past resource allocation schemes, funds for SCI centers were under a "pass through" provision. This, however, did not prevent local VAMC managers reprogramming those funds in the common effort to accommodate total facility budget shortfalls. This resulted in SCI staff shortages, delays in the provision of prosthetic and orthotic appliances, and reduced access for certain non-service connected medically indigent SCI veterans. Now, several centers are closing "excess" beds.

Thus, SCI centers are caught in that same degenerating spiral of annual budget shortfalls that is eroding the entire VA health care system. The prospect of their rejuvenation depends, in the final analysis, on dollars. Only adequate incentive pay will attract and hold SCI qualified physicians and nurses. Contracting for specialist services -- including physiotherapists -- is an option, but that takes even more money.

Ambulatory SCI clinics for supportive treatment of patients in satellite VAMCs are another option now under formal development in VACO. We strongly recommend, however, that these out patient facilities must be organized under the chief of a regional referral SCI Center. The parent-center should be responsible for training and oversight of the satellite clinics' professional staff and the monitoring of SCI patient care.

Recent restrictions on the use of beneficiary travel funding will impede the operation of this program. In-service SCI training for clinic personnel is a necessary component of successful satellite program development and that, also, requires dollars. The VA Regional Medical Education Centers (REMECs) are doing a creditable job in this early stage of program planning, but they, too, are underfunded.

Spinal Cord Injury Medicine is one of those special categories of health care not likely to be covered under any "basic package" in tomorrow's nationally mandated health insurance program. It is, therefore, doubly unfortunate that erosion in the quality of VA SCI center operation has been permitted to occur. Corrective measures must be initiated at once.

VA Medical Care Construction Program

PVA continues to be very concerned about the Tampa and Dallas SCI construction projects. For the most part, our lengthy discussion in testimony before this Committee one year ago concerning the Administration's FY 1991 budget proposals remains true. Both projects represent almost twenty years of frustration for PVA. Most recently, the Tampa project - still in the design stage - changed project supervisors and lost considerable time toward meeting the FY 1993 construction funding schedule. The Dallas project, as well, continues to flounder. Although funds for working drawings were approved, those funds have yet to be released. As these funds sit in escrow and construction is delayed yet another year, spinal cord injured-veterans in the area continue to go without access to an SCI center.

On the upside, the long term SCI facility (not-to be confused with the overall clinical acute care renovation) and power plant (not to be confused with the overall clinical renovation) for Dallas recently received approval for working plans and construction funding. Although building the long term SCI facility prior to completion of the acute care facility may not represent the most logical approach to the overall project, we are grateful for this recent funding approval. We must point out that in the absence of an acute SCI facility, the long term facility must include -- at least on a temporary basis -- clinical and medical support by an inter-disciplinary team of health care providers along with appropriate clinical spaces. We strongly encourage VA to provide a clear medical plan to address the clinical needs of this long term SCI facility in Dallas.

In the past decade, many studies have documented the shortcomings of VA's construction program. Although the causes are well understood and past editions of this Independent Budget have made specific recommendations for improvements, the problems persist. They include:

- excessive time to complete construction projects, resulting in facilities that are inadequate from the time they are activated.

- irrational selection of construction projects for funding and development. VA does not address its most urgent needs first, and appears to have no systematic approach to addressing long-term problems.

- absence of an internal evaluation and improvement mechanism, to resolve systemic problems in the construction process.

We call for VA to keep foremost among its criteria for locating, designing and constructing new VA facilities consistency with its responsibility to deliver quality health care to veterans. VA must define missions for each VA medical center; the mission statements will then serve as the proper starting point for planning, design and construction.

VA must inventory its capital facilities and develop a system for maintaining that inventory. This will enable VHSRA to determine needs from a current information base. The Five Year Facility Plan, the Medical District Initiated Planning Program, the Capital Facilities Studies, and the Facility Development Planning Program did not adequately address construction needs, nor did they solve the construction program's time, design, selection and internal correction problems. Therefore, a new approach is necessary—one that utilizes logical methods for setting national construction priorities.

Once VA establishes construction priorities and funds a project, a single internal entity must manage design and construction. Managers must be responsible for keeping projects on schedule, and resolve problems before they cause delay. VA's deficiency in this regard was cited in the "Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care

Facilities," which Booz, Allen and Hamilton and RTKL Associates completed for VA in April 1985.

The Independent Budget recommends a total of $700 million for VA's Major Construction account in FY 1992 and a total of $253 million for Minor Construction.

Prosthetics and Sensory Aids Service (P&SAS)

Serious indictment was leveled at this service in the FY 1991 Independent Budget. During the past year, there has been measurable improvement of patient services due primarily to additional appropriations provided by the Congress and a VA Central Office (VACO) directive that funds intended for prosthetics and sensory aids will not be diverted to other uses to accommodate VHSRA's budget shortfall. Other recommendations for correction of P&SAS flaws, however, are only now being addressed.

We note with satisfaction the written strategic plans recently submitted to the Chief Medical Director by the Prosthetic Service. Objectives specified in the plan include expansion of the program management and oversight staff, the establishment of additional field services and sections, commitment to educational programs for service personnel, and increased site visits. Centralized management of P&SAS resource allocation will only be effective if the funding is adequate and is promptly disbursed to the field.

Like last year, we continue to propose an additional four million dollars be provided to this service to support fifty additional FTEE and the purchase of needed prosthetic equipment and supplies. Since these resources were not made available last year, even greater need exists this year. P&SAS is charged with serving the most severely disabled veterans, who typically have the highest entitlement priority. We strongly recommend the

provision of these incremental resources in the FY 1992 budget.

Bed and Staffing Levels

VA officials frequently refer to the inefficiency of the congressionally-imposed bed and personnel "floors", or minimums. It is important to understand the history of the mandates. Congress imposed floors in the early 1980s to stem arbitrary OMB bed and personnel reductions. We believe that the fiscal climate remains the same today as in the early 1980s.' Certainly, the VA health care system is a target for reductions to ease the budget deficit. The four veterans service organization sponsors of this Independent Budget believe that the personnel and bed floors should remain in place, to serve the purpose for which Congress established them. This is especially important in today's war-time environment in order to ensure VA's readiness capability in response to Operation Desert Storm.

We recognize that Congress must appropriate funds to support the personnel floor, and have argued successfully for this goal. Congress has recognized this necessity, and has asked VA to identify more accurately, through budget requests, the true requirement for personnel funds. Congress is now moving toward meeting full annual costs of medical personnel increases within that fiscal year's initial appropriation.

Medical Center administrators have argued that centers could be more efficient if Congress did not require them to support personnel floors. They indicate that, in many instances, they do not need the personnel level assigned. We recommend that, in these cases, VA reassign personnel to medical centers and programs that do require additional employees, or use these personnel to initiate programs such as HBHC, or convert hospital beds to nursing home beds. Such systemwide personnel realignment would greatly expand health care capabilities yet contain costs.

The Independent Budget points out the importance of clarifying and monitoring each medical center's mission, programs and activities, and basing staff and resource distribution on each center's mission, programs and expected workload. If VA acted on these recommendations, its personnel could meet more of the projected workload demand. This process would be most effective where the user population is clearly defined. VA could then use existing information to institute an effective resource distribution and control program.

Many medical center administrators have expressed concern about "personnel sub-floors" assigned to their facilities. These sub-floors set minimum staffing levels for indirect healthcare personnel such as administrative or engineering staff. We recommend discontinuing these restrictive sub-floors since they limit the flexibility of facility administrators.

Equipment Backlog

It is clear that the VA equipment purchase backlog has become a serious liability to the Department. Equipment kept in service beyond its normal service life costs more to maintain than to replace. Many medical centers are using outmoded equipment, which could yield inaccurate results and delay patient assessment. The equipment purchase backlog is part of the cycle of inefficiency and declining quality that has resulted from the inadequate budgets of the Eighties. Although VA used a large part of an FY 1989 supplemental appropriation to purchase equipment, equipment purchase backlog continues to increase because more machinery is reaching the end of its useful life, while medical technology, including diagnostic and treatment equipment, continues to advance.

In late FY 1990, the estimated cost to replace outdated equipment with new equipment was $1.2 billion. The Independent Budget recognizes that it is not reasonable to make up this deficit in a single budget year, but insists that VA medical facilities be properly equipped by 1995. Therefore, this years' recommendations call for $100,000,000 to purchase medical and medical support equipment in FY 1992, and we expect that future years will require significant increases in this amount. We congratulate the Administration for proposing $143.7 million in FY 1992 to address this problem. Our $100,000,000 proposal is, of course, in accordance with the Independent Budget's on-going current service levels.

Medical and Prosthetic Research

The VSO authors of the Independent Budget have long believed that VA research's tremendous achievements are not fully appreciated as an integral part of the nations health care system. A viable, quality care system cannot exist without both research and education, along with the provision of care itself.

VA research's prolific yield has served veterans' health care needs and benefitted all Americans. Furthermore, research is essential to VA's academic commitment to its affiliated medical schools, and a strong incentive in recruiting and retaining a high-quality professional staff. VA's Career Development Program, which trains physicians, scientists, and medical researchers, is a national resource. Of these trainees, 37 percent have remained in VA careers, and 20 percent, in academic research.

Inadequate funding for VA's research program threatens to lower staff quality and morale, and, ultimately, the effectiveness of VA graduate medical education, which sustains quality medical care. Years of absorbing pay raises inflation, and OMB-imposed funding cuts to accommodate theoretical productivity increases have eroded the resource base for VA research, just as has been the case for medical care. That however, is not the whole story.

For the past five years, funding has not been consistent, due to episodic, arbitrary OMB cuts. Although Congress each year has appropriated a little more than the Administration requested, resource and personnel fluctuations have been dramatic and disruptive to research programs. Most research projects require years for completion and are funded with commitments for three years or longer. Research teams need stability. Erratic funding impairs research more than a simple examination of resource fluctuations indicates.

In an environment of budget austerity, research funding is commonly the first item decreased. The discrimination is well reflected in recent VA appropriations. In the FY 1991 budget, VA Medical Care received a $1 billion increase over a critically low FY 1991 appropriation, while Medical Research was reduced again, this time from $177 million to $174 million. As in previous years, Congress directed DoD to transfer $20 million from their research account to VA, in FY91 to support research projects applicable to military medicine. DoD, thus far, has not complied with this directive. Should this supplement not be forthcoming in FY 1991, the VA Medical Research program will be in serious jeopardy. As stated earlier, the Administration's proposed budget for FY 1992 does not recommend the $20 million transfer.

Out of concern for the progressive loss of VA research capability, VA Secretary Derwinski has appointed an Advisory Committee on Health Research Policy (ACHRP), consisting of nationally prominent medical research authorities, to analyze the current status of VA research structure, activity and potential and provide recommendations on how to enhance that potential. We look forward to the Committee's report as a guide for future VSO strategy.

We hope that foremost among the Committee's recommendations will be a call for realistic funding of all three components of VA research. By that we mean, at the very least, a resumption of the 1988 level of fiscal support adjusted for inflation.

The Independent Budget recommends a total of $280 million for the Medical and Prosthetics Research account for FY 1992.

The Omnibus Budget Reconciliation Act (OBRA) of 1990

As you know, OBRA 1990 includes a variety of provisions which limit or curtail veterans benefits and services. Other provisions in the OBRA Act generate revenue by imposing fees or co-payments. As part of the Independent Budget, we have proposed our own deficit reduction plan which is discussed in the next section of this testimony. Although most of our recommendations regarding deficit reduction involve veterans benefits programs, there are two health care provisions included in OBRA which we believe should be repealed. They are:

Section 8012 - Copayment for Medications: With the exception of veterans rated 50 percent or more for their service-connected disabilities, this provision requires all other veterans to pay a $2.00 copayment for each 30-day supply of medication. Mr. Chairman, this provision strikes hard at some of the neediest veterans using VA facilities. Further, it is difficult to believe that, after factoring in VA's expenses to collect these co-payments, the government will have saved money. We strongly encourage anyone who has questions about this provision to spend a few hours in the waiting room at his or her nearest VA pharmacy. The vast majority of patients paying for this inequitable answer to deficit reduction are those who are least able to afford it. We encourage your rejection of this provision in OBRA 1990.

Section 8013 - Modification of Health-Care Categories and Copayments: This provision of OBRA 1990 requires that all "discretionary workload" patients (category B and C patients) make copayments of $10 per day for inpatient care (in addition to the copayment based on the Medicare annual deductible), and $5 per day for nursing home care (in addition to the copayment based on the Medicare deductible). Mr. Chairman, for many of PVA's members who must be hospitalized for long periods of time, this provision will potentially impose undue financial hardship. For example, a nonservice-connected paralyzed veteran falling into the "discretionary workload" category, would be required to pay $592 to cover the copayment based on the Medicare deductible plus another $1000 if hospitalized just over three months. The range of inpatient stays for SCI patients in 1990 was between 24 and 159 days.

As you know, a simple injury to the skin of an SCI patient frequently leads to skin breakdown and damage to underlying muscles and bone. It then becomes necessary to replace lost muscle by transplant or graft from an adjacent area. The healing process is extremely slow, often necessitating hospital stays in excess of three months. Unfortunately, skin breakdowns often occur while being hospitalized for unrelated conditions.

With a median hospital stay of 44 days, the typical SCI patient will be burdened with considerable new medical expenses as the result of this unfair OBRA provision. PVA urges your rejection of Section 8013.

VETERANS BENEFITS ADMINISTRATION, GENERAL OPERATING EXPENSES AND BENEFITS PROGRAMS

FY 1991 Funding Outlook - Where VBA Stands Today

Prior Independent Budgets have demonstrated to Congress that VA is not meeting some real veterans' needs because of a series of inadequate VA budgets. Although the House and Senate Veterans Affairs Committees proposed additional GOE resources to provide adequate service to veterans in FY 1991, final appropriations for this fiscal year did not provide those resources. Although adequate for VBA's ADP needs, enacted appropriations are insufficient to support the number of FTEEs the administration needs to improve service to veterans. The FY 1991 appropriated FTEE level of 12,550 is 50 fewer than the FY 1990 appropriated level. VBA's problem is compounded because, while the FY 1991 budget recognizes that the administration needs 145 additional FTEE to comply with the improved decision letters requirement of section 115 of P.L. 101-237, Congress has not provided appropriations to support these additional FTEEs. Unfortunately, VBA's ability to implement a sophisticated ADP system has not reached the point where a reduction of FTEE can be justified in the name of modernization.

Administration's FY 1992 Budget Proposal Versus the Independent Budget's FY 1992 Budget Proposal and Deficit Reduction Plan

At the outset, we must state that the focus on health care issues has, once again, fulfilled our prophecy that the Veterans Benefits Administration, from a budget standpoint, has taken a back seat in the overall budgetary scheme for DVA. If the Veterans Health Services and Research Administration can be called a winner by Congressional Quarterly Magazine in this year's budget proposal, it certainly appears to have produced more than one loser in VBA.

Automated Data Processing (ADP) Systems Management

Prior to our discussion of VBA's ADP program, PVA wishes to express our concern about the Department of Veterans Affairs' overall information resources management effort.

Although we are convinced that the strategy of VA's Office of Information Resources Management (IRM) is properly based on the principle that information is a resource which must be managed from the highest level of an organization, it is apparent to us that intra-departmental clashes involving program responsibilities and philosophical differences have eroded the efforts of the Office of IRM to effectively implement a comprehensive, long-range plan for VA's ADP modernization. VHSRA and VBA, for example, continue to independently forge ahead without the necessary input from IRM to ensure maximum information resource sharing between the two administrations.

The potential value of the enormous quantity of data in VA files is inestimable, but its actual value is extremely limited by its availability and accessibility. Although IRM has been successful in establishing department-wide standards and data base systems, a totally integrated ADP system capable of interaction with a variety of proprietors and consumers will not be achievable without IRM's clear leadership. Although PVA is pleased with the progress made by VBA's ADP effort, we are concerned that VA's overall approach to ADP is being neglected. Transferring 356 FTEE from the Office of Information Resources Management may help VBA - but will it hurt the Department in the long run? We encourage Congressional oversight on this matter.

Regarding VBA's ADP effort, the positive trend noted in the FY 1991 Independent Budget continues. There is innovative, goal-directed and action-oriented management; interim improvements are providing more systems support for VBA operations activities; and the long-range systems modernization plan appears to be on track. Not coincidentally, ADP Systems Management activities are receiving adequate budgetary support. The $42 million proposed for modernization in FY 1992 will continue to provide adequate funding for this important program.

There is one area, however, that needs systems support quickly. P.L. 101-237's improved decision letter requirements are adversely affecting compensation and pension claims backlogs and timeliness, because VBA lacks the FTEEs to perform this additional work. Systems support therefore is essential if further deterioration is not to occur.

Veterans Services

Veterans Services' has a number of planned initiatives to improve service, but they require resources that have not been provided. We believe that Veterans' Services needs the 195 additional FTEE the House Veterans' Affairs Committee recommended for FY 1991 to be able to provide (1) VA's standard for acceptable telephone access; (2) at least one VBC in each large metropolitan area and in each VAMC; and (3) support for the TAP/DTAP programs. Veterans' Services also need funds for additional phone lines, training, equipment and technologies to aid benefit dissemination.

The Administration is requesting a decrease of 31 FTEE for Veterans Services from the 1991 level. This reduction, once again one of the largest in VBA, will continue to widen the gap between the Administration's recommendation for the program and that of the Independent Budget. Further, although 2,132 FTEE have been requested for FY 1992, 96 of these FTEE are to be used to enforce OBRA 1990.

Although the Administration has provided "growth through reconciliation", they have provided nothing for Veterans Services to deal with the Transition Assistance Program (TAP). In view of DoD troop reduction plans which are still in effect and the enormous number of Reserves who will have veteran status as the result of Desert Storm, the Veterans Services Division can expect literally tens of thousands of TAP enrollees in excess of what was estimated last year. Mr. Chairman, with an actual FTEE level currently hovering around 2,060, this important front-line service to veterans is severely understaffed for the task ahead.

Adjudication

The Administration has recommended an increase of 30 FTEE to support the staff required to adjudicate OBRA cases. At the same time, "growth through reconciliation" is offset by the reduction of 59 FTEE resulting from the implementation of modernization short-term initiatives. As stated earlier, VA is not in a position to reduce this service by 59 FTEE in the name of modernization. The backlog of claims represents far too great a problem and can only be resolved through an adequate number of adjudicators.

The size of the compensation and pension claims backlog has been a matter of some controversy. In the FY 1991 Independent Budget the VSOs calculated the backlog using VA reports that showed cumulative 12-month claims receipts and dispositions. VA challenged the VSOs backlog figure stating that it was not 654,392, as the Independent Budget indicated, but rather 343,199. The VSOs met with VA management officials to resolve the issue. VA acknowledges a problem in its reporting system, but maintains that its reported pending claims data are accurate. VA is taking steps to identify and correct the reporting problem (which it believes is due to double counts). VBA reported a 9/30/90 backlog of 377,767. Regardless of the backlog's size, the untimeliness of case processing remains dismal and there are far too few adjudicators in VBA to resolve the problem -- modernization or no modernization.

Vocational Rehabilitation and Education

The need for additional FTEEs to provide vocational rehabilitation and counseling services to service-connected disabled veterans has been recognized for years. The seriousness of VA counselors' large pending workloads can quickly be demonstrated by looking at the numbers. Veterans must still wait over three months from the time an original application is filed until an interview can be held with a counseling psychologist. With every delay over the course of one's rehabilitation, the benefits of the service will diminish.

In addition to an adequate number of FTEE, VBA's vocational rehabilitation efforts can certainly be improved with management initiatives such as those recommended in the case management study submitted in July 1988, by the Veterans Advisory Committee on Rehabilitation. It is essential that the Secretary of Veterans' Affairs, the Chief Benefit Director and Chief Medical Director take action to enable this important benefit program to be delivered by a cohesive and united team (including both VHSRA and VBA), one with identical objectives, and one that can properly prioritize vocational rehabilitation within the spectrum of all benefit programs and medical activities.

Mr. Chairman, the rehabilitation of disabled veterans provides an extremely beneficial service to both the individual and the nation as a whole. PVA urges you to adopt the funding recommendations set forth in the Independent Budget for this program.

Loan Guaranty

All indicators for FY 1990 show major improvements in VA's home loan program. Compared to FY 1989, the number of defaults reported declined from 171,295 to 163,959, and the number of defaults pending declined from 126,877 to 116,522. The number of personal contacts increased from 163,576 to 182,199, and the number of successful interventions increased from 3,123 to 5,400. Of particular significance is the increase in the Foreclosures Avoidance with VA Involvement Ratio (FAVIR), from 2.8 percent to 4.6 percent.

This improved performance occurred during FY 1990, hardly a banner year for the economy or the real estate market. Thus, we cannot credit the results to good times or good luck. The improvement occurred, despite unfavorable economic and market conditions, because of good management practices, enhanced ADP support, and additional FTEE deployment for the loan service and claims and property management functions.

The Independent Budget recommends 150 additional FTEEs for the Loan Guaranty function. However, because we have lost faith with the GOE appropriations process, we believe the Loan Guaranty Revolving Fund (LGRF) should provide funding for the additional FTEEs. In fact, the home loan program's demonstrated performance improvement justifies LGRF funding all program administrative costs.

The Administration has recommended a decrease of 114 FTEE for the loan guaranty program. In justifying that reduction, VA acknowledges that the reduction is partially the result of a workload decline due to a past increase in FTEE to improve monitoring of lenders and loan servicing. The Administration should learn from VA's experience with the Houston project and stop further reductions in the program's FTEE level.

The Administration's Legislative Proposals Affecting VA Benefits

The President's budget recommends a number of new legislative initiatives which involve VA benefits issues. The enactment of these initiatives would:

* Index the compensation COLA to the annual change in the Consumer Price Index. PVA continues to oppose this initiative and believes this Committee should continue to establish such COLAs by legislation each year.

* Lift the sunset dates on certain provisions of OBRA 1990. PVA believes these date should remain in place.

- Standardize DIC payments. Reform in the DIC formula is long overdue. Although we are in agreement with VA that a formula based on military rank is entirely unfair to the vast majority of DIC recipients, PVA remains strongly opposed to the "flat rate formula" proposed by the Administration. A truly equitable DIC formula must take into consideration the veteran's degree of disability. We urge this Committee to reject the "flat rate" formula and **work with PVA to implement an equitable formula which recognizes both degree of and duration of disability. We plan to discuss this issue in length at the time of our** Annual Testimony on February 28, 1991, before this Committee.

- Limit eligibility for Chapter 31, Vocational Rehabilitation, to veterans rated 30 percent or higher. PVA opposes this initiative.

- Add resale loss to net value calculations and exempt GNMA from VA no-bids. PVA supports this initiative.

- Merger of Direct Loan and the Loan Guaranty Revolving Fund. PVA opposes this provision.

- Require a 2.5 percent fee and 10 percent downpayment on multiple use of VA's home loan benefit. PVA opposes this initiative.

The Administration also failed to request an inflation increase in basic GI Bill education benefits in which a majority of Desert Storm personnel have invested. Such benefits have not been increased since the program's 1985 inception.

Independent Budget Legislative Proposals

The Independent Budget recommends the enactment of legislation which would improve a variety of VA health care and benefit programs. In brief, the enactment of these initiatives would:

* Establish August 2, 1990 as beginning date for "wartime service" for the purpose of VA benefits and health care for veterans of the Persian Gulf war.

* Increase the maximum face value of Veterans' Mortgage Life Insurance (VMLI) policies from $40,000 to $90,000.

* Provide the availability of $10,000 supplemental life insurance for Service Disabled Veterans' Insurance (SDVI) policy holders who have waiver of premiums in effect.

* Increase the maximum limitations on VA's Home Improvements and Structural Alterations (HISA) grants from $2500 to $5000 for service-connected veterans and from $600 to $1200 for nonservice-connected veterans.

* Require VA to provide for the payment, on an interim basis, of compensation, Dependency and Indemnity Compensation (DIC), and pension benefits to veterans and their survivors/dependents if their claims for such benefits are not decided within established time limits.

* Provide Category A veterans with entitlement to the full array of VA health care services - inpatient hospital, outpatient, long term and nursing home care.

* Mandate the establishment of a veterans' cemetery in every state.

- Require specific appropriation support for any VA medical programs for veterans who meet eligibility requirements in accordance with Congressionally mandated entitlements.

- Expand programs to provide improved inpatient and outpatient treatment for veterans suffering from PTSD.

- Provide program enhancements for the homeless.

- Provide total exemption from sequestration of VA's medical care account.

- Establish a pilot program to assess veterans' unmet needs for medical care through a national survey and catchment study.

- Provide appropriate pay increases for VA physicians and dentists.

- For the purposes of VA's Home Loan Program, require VA to consider the value of resale losses when determining whether or not to acquire a foreclosed property.

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The VSO's Deficit Reduction Plan is discussed in detail in the Independent Budget. The plan includes support for VA's General Operating Expenses (GOE) account through the Loan Guaranty Revolving Fund and Compensation/Pension Benefits Programs. The following legislative proposals, in brief, constitute critical elements of that plan and include the repeal of fourteen provisions of Title VIII of the Omnibus Budget Reconciliation Act of 1990 (OBRA) and the enactment of several new initiatives.

The Independent Budget calls for the repeal of the following provisions of OBRA 1990 which amend title 38, United States Code and the Internal Revenue Code of 1986:

- Section 8002. Limitation on Compensation for Certain Incompetent Veterans. PVA strongly supports the repeal of this section of OBRA. This provision is directed at the most vulnerable of all compensation recipients and actually imposes needs-based requirements on these service-connected individuals. Although legislation was passed to enhance the rights of incompetent individuals under the Social Security system, service-connected veterans have been asked to sacrifice their compensation to meet the targets of budget reconciliation.

PVA also supports the repeal of the following sections of OBRA 1990 and will address these issues in more detail in our Annual Testimony on February 28, 1991.

- Section 8002. Elimination of Presumption of Total Disability in Determination of Pension for Certain Veterans.

- Section 8003. Reduction in Pension for Certain Veterans Receiving Medicaid-covered Nursing Home Care.

- Section 8004. Ineligibility for Reinstatement of Benefits for Remarried Surviving Spouses or Married Children Upon Becoming Single.

- Section 8012. Co-payment for Medication.

- Section 8013. Modification of Health Care Categories and Co-payments.

- Section 8021. Limitation of Vocational Rehabilitation Program Entitlement to Service-Disabled Veterans Rated at 20 Percent or More.

- Section 8032. Increased VA Loan Fees.

- Section 8041 Elimination of Headstone or Marker Allowance.

- Section 8042. Limitation of Plot Allowance Eligibility.

- Section 8051. Under the amendments to Subparagraph (D) of section 6103 (1)(7) of the Internal Revenue Code of 1986, repeal the phrase, "or any other law administered by the Secretary of Veterans Affairs," contained in (c)(viii)(I). Under the amendments to section 3117, Chapter 53, title 38, USC, repeal subsection (d) GAO Study.

- Section 8052. Line of Duty - Secondary Effects of Willful Misconduct.

Mr. Chairman, the passage of the Omnibus Budget Reconciliation Act of 1990 (OBRA) took place in an environment that neither invited nor permitted sober analysis of what was being done to VA benefit programs. Having reflected on the OBRA legislation, PVA strongly believes that the implementation of support for VBA's GOE account, as discussed in detail in the Independent Budget, coupled with the repeal of the above provisions, will provide mandatory savings in an equitable manner.

NATIONAL CEMETERY SYSTEM (NCS)

VA's FY 1991 budget request of $54.8 million was clearly inadequate because, among other things, it did not address a growing equipment purchase and maintenance backlog. In testimony before this Committee, VA stated that it needed additional funds to purchase equipment, ranging from grass trimmers to backhoes and trucks. It also needed funds for maintenance and repair and to purchase supplies and materials such as fertilizer and seed, which were exhausted. Funds for watering were often not available. As a result, appearance of some cemeteries had fallen far short of appropriate standards.

NCS received only $53.5 million in appropriations for FY 1991. Therefore, for FY 1992 the VSOs recommend an NCS appropriation of $71.9 million, an increase of $18.4 million over the FY 1991 appropriated level.

Mr. Chairman, that concludes my testimony. I will be happy to answer any questions you may have.

VA Appropriations By Account
(dollars in thousands)

GENERAL OPERATING EXPENSES (GOE) AND MISCELLANEOUS	1991 Appropriation	1991 IB Current Services*	1992 IB Current Services*	1992 IB Recommended Appropriation	1992 President's Budget
General Operating Expenses**	$902,514	$902,514	$965,083	$976,583	$847,204
Grants for the Construction of State Veterans Cemeteries	3,946	3,946	4,112	4,112	5,104
Office of the Inspector General	24,859	24,859	25,903	25,903	29,959
Reimbursements				(142,721)	
TOTAL GOE AND MISCELLANEOUS	$931,319	$931,319	$995,098	$863,877	$882,267
BENEFITS PROGRAM					
Compensation, Pension, and Burial Benefits	$15,684,451	$15,684,451	$15,209,420	$15,209,420	$15,209,420
Readjustment Benefits	502,500	502,500	635,400	635,400	635,400
Veterans Insurance and Indemnities	15,410	15,410	25,740	25,740	25,740
Veterans' Job Training Fund	0	0	0	0	0
Loan Guaranty Revolving Fund	670,700	670,700	373,100	373,100	373,100
Guaranty and Indemnity Fund	80,800	80,800	74,200	74,200	74,200
Credit Reform Costs	--	--	635,000	635,000	624,621
TOTAL BENEFITS PROGRAMS	$16,953,861	$16,953,861	$16,952,860	$16,952,860	$16,942,781
MEDICAL PROGRAMS					
Medical Care	$12,310,490	$12,919,600	$14,020,600	$14,889,850	$13,287,096***
Medical and Prosthetic Research	216,795	245,800	279,700	282,700	216,795
Medical Administration and Miscellaneous Operating Expenses	41,434	53,030	55,550	55,550	40,479
Health Professional Scholarship Program	10,113	--	5,000	5,000	10,113
Grants for Construction of State Extended Care Facilities	70,000	42,000	70,000	70,000	85,000
Grant to the Republic of the Philippines	484	500	500	500	500
TOTAL MEDICAL PROGRAMS	$12,649,316	$13,260,930	$14,431,350	$15,303,600	$13,639,983
CONSTRUCTION PROGRAMS					
Construction, Major Projects	580,000	580,000	580,000	699,600	450,000
Construction, Minor Projects	130,640	130,640	130,640	352,300	195,701
Parking Garage Revolving Fund	28,900	28,900	28,900	25,000	8,536
TOTAL CONSTRUCTION PROGRAMS	$739,540	$739,540	$739,540	$1,076,900	$854,237
TOTAL APPROPRIATION	$31,274,036	$31,885,650	$33,118,848	$34,197,237	$32,119,268

*Funds necessary to maintain services at the FY 1988 level.

**Independent Budget figures do not include major appropriations items such as ADP and non-ADP equipment purchase and maintenance.

***Does not include Medical Care Cost Recovery

TABLE
Medical Care
Components of Independent Budget Recommended Appropriation

	(dollars in thousands)
FY 1991	
Current Services Level	$12,919,600
FY 1992	
Payroll Related Increases	
Retirement Programs	51,000
Annualization of 1991 Pay Raise	130,000
Annualization of 1991 Federal Employee Health Benefit	10,000
Pay Raise 1992	205,000
Within Grade Pay 1992	65,000
Health Benefits 1992	25,000
Variation in No. Workdays	30,000
Locality Pay	30,000
Inflation	250,000
Facility Activations	50,000
Adjustments to FY 1991 Program Base	120,000
Adjustments for Rate Changes	
State Home Nursing Home	13,500
Community Nursing Home	18,000
Miscellaneous	
Property Rental	1,000
AIDS	52,500
Special Pay to Clinical Personnel	50,000
TOTAL CURRENT SERVICES LEVEL 1992	$14,020,600
Additional Initiatives 1992	
Extended Care Program	364,000
Outpatient Workload Increase	215,000
Homeless Programs	5,000
Post-Traumatic Stress Disorder (PTSD)	7,250
Long-term Psychiatric Care	1,000
Blind Veterans Rehabilitation	1,500
Prosthetics and Sensory Aids	4,000
Education and Training	157,000
Decentralized Hospital Computer Program	14,500
Equipment	100,000
FY 1992 RECOMMENDED APPROPRIATION	**$14,889,850**

PRESIDENT'S BUDGET - MEDICAL PROGRAMS
Additional Proposed FY '92 Funding over FY '91

INCREASED REQUESTED APPROPRIATION		**$1,000,167**
New Unavoidable Program Expenses		
Post Fund.....................	- 500	
MCCR..........................	- 9,000	
Philippine Grant..............	- 16	
State Homes Grant.............	- 15,000	
TOTAL UNAVOIDABLE EXPENSES	-24,516	
APPROPRIATION LESS UNAVOIDABLE PROGRAM EXPENSES		**$ 975,651**
Savings from MAMOE cut..........	+ 955	
BALANCE AVAILABLE FOR MEDICAL CARE		**$ 976,606**
New Unavoidable Medical Care Expenses		
Raise in Pay and Benefits.......	- 581,003	
Nurse Special Pay...............	- 31,660	
Residents' Compensation.........	- 100,000	
Calender Day....................	- 1,679	
Inflation.......................	- 279,526	
Postage Increase................	- 5,129	
State Homes Grant...............	- 10,910	
Real Property Rental............	- 7,621	
Regional Office Move............	- 444	
TOTAL EXPENSES	- 1,017,972	
BALANCE AVAILABLE FOR MEDICAL CARE		**$ -41,366**
NEW OMB MANDATED INITIATIVES FOR VA MEDICAL CARE		
Capital Investment..............	- 143,701	
Alcohol Rehabilitation..........	- 15,000	
Unit Pharmacy Dose System.......	- 6,614	
One new GRECC...................	- 2,500	
TOTAL INITIATIVES	- 167,815	
TOTAL NEW MEDICAL CARE EXPENSES		**$-209,181**
OMB'S DIRECTION FOR MAKING UP THE DEFICIT		
MCCR Administrative Savings...	$ 20,208	
Pay Reform...................	55,700	
Activations (Excess in Base)..	28,269	
Transfer Hosp. Workload to O.P	70,000	
Adopt Medicare Pay Rates......	35,000	
TOTAL SHADOW SAVINGS	209,177	
FY 1992 NET DEFICIT		**$ -4,000**

A NATION'S COMMITMENT

A MATTER OF HONOR
TO THOSE
WHO SERVE

FISCAL YEAR 1992
INDEPENDENT BUDGET FOR VETERANS AFFAIRS

PROLOGUE

This is the fifth year that American Veterans of World War II, Korea and Vietnam (AMVETS), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW) have formulated and presented to Congress a detailed budget designed to meet veterans' needs through programs administered by the Department of Veterans Affairs (VA). Our motivation, as in past years, is a recognition of need to overcome the Office of Management and Budget's impediment to full disclosure of VA program resource requirements.

Our purpose is to depict the status of veterans programs based on projections of veteran demand. We itemize the resource levels required to meet those projections in terms of today's dollars and identify programs, services and resources needed for VA to meet future needs of the veteran population.

The Independent Budget shows what is actually needed—rather than what has only been provided—for veterans' health care and benefit programs. It does not rely only on the arbitrary restraints and artificial limitations of the federal budget process.

Our budget estimates are designed to give Congress, as well as the extended veteran community across the country, a benchmark from which to judge and advocate a better course for veterans' benefits and services.

Today, thousands of young Americans are being asked to match the sacrifices of the millions of veterans who served in defense of this nation before them. Now, more than ever, we believe it is essential that our government maintain the quality and quantity of veterans' benefits and services through top priority funding equal to, if not greater than, that provided other federally sponsored programs. As a grateful nation, we must live up to our President's words; "Our commitment to them must be the equal of their commitment to their country. They are truly America's finest."

Vaughn L. Brown, Sr.

Vaughn L. Brown, Sr.
National Commander
American Veterans of World
War II, Korea and Vietnam

Joseph E. Andry

Joseph E. Andry
National Commander
Disabled American Veterans

Victor S. McCoy

Victor S. McCoy, Sr.
National President
Paralyzed Veterans of America

James L. Kimery

James L. Kimery
Commander-in-Chief
Veterans of Foreign Wars
of the United States

ENDORSEMENTS

Alliance for Aging Research

American Association of Dental Schools

American Association of Spinal Cord Injury Nurses

American Association of Spinal Cord Injury Pyschologists and Social Workers

American Ex-Prisoners of War

American Federation of Government Employees

American Nurses Association

American Optometric Association

American Paraplegia Society

Association of American Medical Colleges

Blinded Veterans Association

Catholic War Veterans, U.S.A., Inc.

Jewish War Veterans of the U.S.A.

Military Order of the Purple Heart

National Association of VA Physicians and Dentists

National Council of Senior Citizens

Nurses Organization of Veterans Affairs

Non-Commissioned Officers Association of the U.S.A.

Polish Legion of American Veterans, U.S.A.

United Spanish War Veterans

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INTRODUCTION

This is the fifth year that four Congressionally-chartered veterans service organizations (VSOs) have cooperated to develop and present to Congress a budget proposal that addresses veterans' needs and the resources the Department of Veterans Affairs (VA) requires to meet those needs. The Prologues to these annual Independent Budget documents have retained the candid annual statement defining our initial motivation for this project—namely, our loss of confidence in the Office of Management and Budget's (OMB) ability to objectively address veterans' issues, or to give unqualified support to our nation's moral and legal obligations to the men and women who have served in defense of our country. That lack of confidence remains because administration budgets continue to fall short of program needs.

The Independent Budget will remain a documented account of the damage of a decade of budget shortfalls.

Each year the Independent Budget has been well received in Congress, particularly as an effective counterpoint to the administrations' budget requests. The appropriation response, however, has varied. During these past four years, Congress has added approximately two billion dollars over the administrations' recommended budgets. Yet sizeable shortfalls occurred again in FY 1990, and at least a $600 million shortfall is expected for VA medical care in the current fiscal year, since Congress essentially accepted the Administration's initial budget figures for FY 1991.

The environment for Congressional budget construction has now become more contentious, the nation's economy more weak and the budget deficit more alarming. Further, the enormous additional expense of salvaging the savings and loan industry and the resource demands of Operation Desert Storm assure a protracted period of budget austerity. Even without a recession, we now face years of fiscal deprivation before the national debt is reduced to manageable proportions. And, with Congress's current five-year budget agreement, veterans' programs are capped at a point when the resource allotment already falls below the actual need, not withstanding the increasing need expected with the aging of the veteran population.

The authors of the Independent Budget have resolved the quandary of whether to surrender to this budget reality or to continue to compute resource need built on the FY 1988 workload targets. We intend to do both. While tempering our proposed FY 1992 VA appropriation request with suggestions for alternate cost savings and necessary legislative changes to right the wrongs to veterans resulting from the budget reconciliation process, we feel constrained also to continue an accounting of true current service requirements in all program areas. The Independent Budget will thus remain a documented account of the damage of a decade of budget shortfalls.

There is a direct correlation between the inadequate resources previous federal budgets have provided and veterans' experience of inadequate health care, benefit and service delivery. Chart 1 displays comparisons between federal health programs. VA health programs have shown the smallest percentage increase of all major government health programs between 1985 and 1991.

An honest assessment of what is required to provide the health care and benefits to which veterans are entitled should be the cornerstone of the budget formulation process. Budget cuts to federal programs servicing the private sector are not cost savings; as with Medicare, they are primarily cost shifts to other funding sources. However, no alternative funding source exists for veterans programs, including those for the provision of health care.

Advocates for veterans' needs had long since supported the rationale that all dollars saved through reduced benefit expenses, due to the expected annual decrease in numbers of veterans, should be maintained for the VA health care system. Counterbalancing the decline in veteran population, however, is the growing numbers of aged veterans. This geriatric imperative alone requires a progressive increase in annual medical care budgets. Now, however, the assumption of a future with fewer veterans may prove to be as fleeting as the recent prospect of a "peace dividend." The system, which is failing to meet the current demand for services, is completely unprepared to accommodate another generation of combat veterans from the Persian Gulf or elsewhere. Operation Desert Storm forceably reminds us that a sustained integrity of veterans affairs is a vital component of national security and that the stand-by strength of military contingency support must not be a some-time thing. Nor does the peacetime erosion of benefits for today's veterans offer much assurance to those who follow.

Frankly, the new budget reality is not only frustrating, but frightening. With the recent Omnibus Budget Reconciliation Act of 1990 (OBRA), veteran benefits programs—previously considered immune—are now under the axe. Those programs cover four major activities: Compensation and Pensions (C&P); Readjustment Benefits (RB); Veterans' Insurance and Indemnities (VI&I); and the Home Loan Guaranty Program, which is funded by the Loan Guaranty Revolving Fund (LGRF) and the Guaranty and Indemnity Fund (GIF). Benefit payments from these accounts result from determinations that veterans, their dependents and survivors meet eligibility requirements set by law. Once those requirements are met, benefit payments are nondiscretionary; that is, the government must make the predetermined payments.

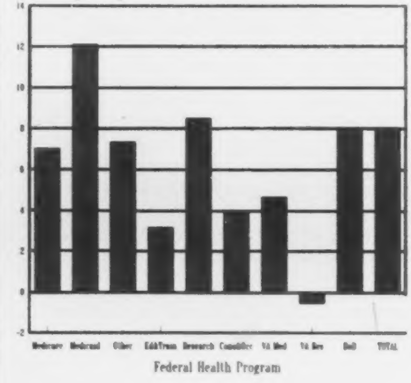
The 1990 OBRA, which incorporates all legislation designed to reduce the federal budget deficit by $40 billion in FY 1991 and $500 billion in FYs 1991-1995, contains a number of decremental provisions directly affecting veterans' benefits programs. These reduction targets were chosen to meet the assigned VA budget savings of $620 million for FY 1991 and $3.35 billion for FYs 1991-1995.

The VSOs find reductions targeting these benefits to be onerous, discriminatory, and, in fact, unnecessary. They are unfair because veterans' programs alone among federal benefits programs have been singled out for entitlement cuts. Moreover, the same legislation that includes these cuts contains entitlement enhancements in other federal programs, for example, Social Security. The veterans' entitlement cuts are unnecessary because deficit reduction targets can be met and exceeded without them.

We have therefore formulated an alternative deficit reduction plan which, while avoiding veterans entitlement cuts, offers the potential of exceeding the assigned reconciliation targets. This plan is presented in the "Summary of Recommendations" and again in the "Benefits Programs" section. Some provisions of OBRA—that is, allowing VA access to Internal Revenue Service and Social Security Administration data to ensure correct entitlement and benefit amount determinations—are cost-effective and do not change eligibility criteria. The VSOs support these provisions. In fact, we recommend that they be made permanent by removing their legislatively-mandated sunset dates.

We titled last year's Independent Budget publication, "The Price of Peace," alluding to that ephemeral peace dividend. Perhaps we should call this year's Independent Budget document, "The Voice in the Wilderness." Our admonition is not without despair: The deterioration of veterans' medical care, which long ago reached crisis proportions, continues to worsen, as do non-medical program benefits and service delivery, because of perennially insufficient appropriations.

CHART 1
Federal Health Budget
Average Annual Percentage Change
FY 1985-1991



Source: Budget of the US Government

GUIDING PRINCIPLES

As in past years, this proposed Fiscal Year 1992 budget is based upon a set of principles and guidelines agreed upon by the four sponsoring Congressionally-chartered veterans service organizations. These principles and guidelines reflect a shared underlying philosophy regarding veterans' programs. Consistency is maintained by limiting modifications to accommodate only significant environmental changes.

- VA should site and staff its facilities to serve veterans in areas of the country having the greatest demographic need for veterans' services. Mission changes are in order. For both health care facilities and regional offices this means a geographic realignment parallelling any major population shift of veterans to the "Sun Belt". Realignment may require new facilities as well as expansion or modification of existing ones. For cemeteries, this means a national cemetery in every state.

- VA must implement an information resource management plan and give priority to upgrading and integrating automated data processing systems within and between the Department's administrations. The current, lack of systems integration is an important cause of deficient service delivery.

- Under effective strategic planning VA should better anticipate the impact of altered Administration policy and accurately develop workload and funding budgets to accommodate such changes. In the current environment, the very real prospective impact of mass combat casualties from Operation Desert Storm must not find VA contingency capability wanting. Simultaneously a very significant announced reduction in military ranks could cause an overwhelming workload of claims processing for veterans' benefits.

- The budget process should not persist in arbitrary assumptions of annual productivity improvement with estimated dollar decrements prospectively assigned.

- The deficit reduction targets of the Omnibus Budget Reconciliation Act of 1990 (OBRA) can be met and substantially exceeded without any entitlement cuts.

- There should be no discriminatory denial—or delay—of Cost of Living Allowances (COLA). The VSO authors of the Independent Budget have repeatedly assured Congress that we support any COLA modification *if* it is applied "across the board" to *all* federal departments, agencies and accounts.

- Estimates for payroll cost increases necessary to maintain the FTEE ceiling established in appropriation language should continue to be included in the fiscal year budget for which these increases are anticipated. Contrary to the Administration's attempts to dissuade Congress from mandating VA personnel floors, we urge the floor mandate continuance, to protect the Department from OMB's demonstrated arbitrary reductions in FTEEs. We do not, however, favor "sub-floors"—that is, ceilings on different categories of personnel—which unduly restrict local management flexibility.

- Savings in excess of deficit reduction targets should be retained for use by VA and invested in improving health care and benefits service delivery to veterans. Similarly, any cost savings in compensation and pensions programs from reduced numbers of veterans should also be diverted to other increasing veteran program needs.

- Primary responsibility for veterans' nursing home care rests with the federal government—not the individual states. Veterans' military service obligation was a federal commitment; we therefore hold that a converse obligation now exists.

- VA's critical role in shared responsibility for the education and training of the nation's health professionals must not be compromised through underfunding. Equally essential is adequate funding of continuing education for staff members of the Department of Veterans Affairs.

- We remain dedicated to maintaining adequately and consistently the VA research program's high caliber and integrity.

SUMMARY OF RECOMMENDATIONS

We present, in tabular form, a summary of recommendations covering all four major sections of the VA budget. For brevity and avoidance of redundancy, narrative description of programs, resource needs, and initiatives justifying the recommended actions are confined to the respective document sections.

There follows a summary table of the entire budget proposal identifying, by account, current services figures constructed from the baseline of Fiscal Year 1988, that being the last year budget shortfalls did not severely constrain VA workload. Table 14 also shows the Independent Budget recommended appropriations including the costs of program enhancements.

Finally, an abbreviated listing of legislative proposals is provided. Five of these proposals are brought foward from last year.

In past years we generally have not included, in the Independent Budget appropriation requests, dollars or FTEEs in anticipation of legislative action. The one exception has been, and is again this year, the request for up-front total appropriation covering anticipated pay raises. Also, the Independent Budget proposal for alternative means of accommodating the VA reconciliation budget reduction targets references in part the need for corrective legislation.

TABLES OF RECOMMENDATIONS AND RESOURCE IMPLICATIONS
INDEPENDENT BUDGET FY 1992

TABLE 1
Benefits Programs
Recommendations for VSO Deficit Reduction Plan

REPEAL THE FOLLOWING PROVISIONS OF OMNIBUS BUDGET RECONCILIATION ACT (OBRA) OF 1990:

Compensation, DIC and Pensions

Section 8001: Places limitation on compensation for certain incompetent veterans (sunsets 9/30/92)
Section 8002: Eliminates the presumption of total disability in determination of pension for certain veterans
Section 8003: Reduces pensions for certain veterans receiving Medicaid-covered nursing home care (sunsets 9/30/92)
Section 8004: Makes remarried surviving spouses or married children ineligible for reinstatement of benefits eligibility upon becoming single

Health-Care Benefits

Section 8012: Enforces co-payments for medication (sunsets 9/30/91)
Section 8013: Modifies health-care categories and co-payments (sunsets 9/30/91)

Education and Employment

Section 8021: Limits vocational rehabilitation program entitlement to service-disabled veterans rated at 20 percent or more

Housing and Loan Guaranty Assistance

Section 8032: Increases loan fees

Burial and Grave Marker Benefits

Section 8041: Eliminates headstone or marker allowance
Section 8042: Limits plot allowance eligibility

Miscellaneous

Section 8052: Affects eligibility for benefits in cases of secondary effects of willful misconduct

RETAIN THE FOLLOWING PROVISION OF OBRA:

Section 8011: Medical-care cost recovery (sunsets 9/30/93)
SAVINGS: FY 1991- $113 million; FY 1992- $192 million
TOTAL SAVINGS FYs 1991-1995 - $826 million

TABLE 1 (continued)
Benefits Programs
Recommendations for VSO Deficit Reduction Plan

RETAIN AND MAKE PERMANENT THE FOLLOWING PROVISION OF OBRA:

Miscellaneous

Section 8051: Use of IRS and SSA data for income verification (currently sunsets 9/30/92)
SAVINGS: FY 1991- $90 million; FY 1992- $140 million
TOTAL SAVINGS FYs 1991-1995 - $933 million

RECOGNIZE THE SAVINGS FROM THE FOLLOWING PROVISION OF OBRA:

Miscellaneous

Section 8053: Require claimants to report Social Security Numbers (for death verification)
SAVINGS: FY 1991- $4 million; FY 1992- $7 million
TOTAL SAVINGS FYs 1991-1995 -$47 million

CREDIT ADDITIONAL SAVINGS TO BENEFITS PROGRAMS AS FOLLOWS:

Pensions

Recognize as savings in each year pension spending that will be below OBRA limits, at least by the rate of inflation
SAVINGS: FY 1991- $138 million; FY 1992- $168 million
TOTAL SAVINGS FYs 1991-1995 - $822 million
Recognize as savings actual pension reductions
SAVINGS: FYs 1991- $40 million; FY 1992- $40 million
TOTAL SAVINGS FYs 1991-1995 - $200 million

Compensation

Recognize as savings in each year compensation spending that will be below OBRA limits, at least by the rate of inflation
SAVINGS: FY 1991- $610 million; FY 1992- $219 million
TOTAL SAVINGS FYs 1991-1995 - $1.52 billion
Credit one-month COLA delay and savings resulting from additional months' COLA delay
SAVINGS: FY 1991- $49 million for one-month delay plus amount to be determined for additional months' delay

Home Loan Guaranty

Authorize 150 additional FTEEs for default and foreclosure avoidance
SAVINGS: FY 1991- $100 million; FY 1992- $225 million
TOTAL SAVINGS FYs 1991-1995- $1 billion
Require by law that resale losses be included in net values for the VA formula used to determine whether to acquire foreclosed properties
SAVINGS: FY 1991- $80 million; FY 1992- $46 million
TOTAL SAVINGS FYs 1991-1995- $445 million

AMEND THE FOLLOWING LEGISLATION AFFECTING OBRA:

Section 8051: Use of IRS and SSA data for income verification (sunsets 9/30/92)
-Under the amendments for Subparagraph (D) of section 6103(1)(7) of the Internal Revenue Code of 1986, repeal only the phrase, "or any other law administered by the Secretary of Veterans Affairs" contained in (c)(viii)(I)
-Under the amendments of Chapter 53, Title 38, United States Code, section 3117, repeal only subsection(d), GAO study

OTHER PROGRAM IMPROVEMENTS

Veterans Insurance and Indemnities

-Increase Veterans' Mortgage Life Insurance (VMLI) maximum face value from $40,000 to $90,000
-Provide the availability of $10,000 supplemental life insurance for Service Disabled Veterans' Insurance (SDVI) policy holders who have waiver of premiums in effect

TABLE 2
Savings from VSO Deficit Reduction Plan

Total Savings Recognized in VSO Deficit Reduction Plan:		Savings Targeted In Omnibus Budget Reconciliation Act of 1990:		Difference in Recognized Savings:	
FY 1991	$1.094 billion	FY 1991	$ .620 billion	FY 1991	$ .474 billion
FY 1992	$1.037 billion	FY 1992	$ .818 billion	FY 1992	$ .219 billion
FYs 1991-1995	$5.711 billion	FYs 1991-1995	$3.350 billion	FYs 1991-1995	$2.361 billion
FYs 1992-1995	$4.617 billion	FYs 1992-1995	$2.730 billion	FYs 1992-1995	$1.887 billion

TABLE 3
Comprehensive Recommendation For Benefits Programs

Use incremental savings from FYs 1991-1995 of $2.361 billion to implement legislative proposals and improve health care and benefit services to veterans

TABLE 4
General Operating Expenses

Veterans Services
-Provide an additional 195 FTEE through GOE appropriations
$ $7 million
Loan Guaranty Revolving Fund
- Provide an additional 150 FTEE through funding for Loan Guaranty Revolving Fund
$ $4.5 million
Compensation and Pensions
-Legislate an entitlement to reasonable timeliness standards for the adjudication of Compensation and Benefit Claims
-Support the Veterans' Claims Administration Equity Act (HR 141) re-introduced in 102nd Congress by Rep. McEwen

Education and Employment
-Legislate an entitlement to reasonable timeliness standards for delivery of vocational rehabiliation and counseling services
-Support the Veterans' Claims Administration Equity Act (HR 141) re-introduced in 102nd Congress by Rep. McEwen

National Cemetery System
-Maintain FY 1991 appropriated level in FY 1992
$ $53.5 million
-Provide revenues needed for items mentioned in HVAC Budget Report
$ $16.3 million including 100 additional FTEEs
-Fund to remedy shortfall in deferred maintenance and repair
$ $2.1 million

Total $71.9 million

General Administration
-Determine funding and appropriate FTEE levels to meet with reasonable timeliness standards for appealed claims set in Veterans' Claims Administration Equity Act (HR 141)

TABLE 5
Current Medical Care Services

Payroll and Inflation
Payroll
-Provide pay raise in initial appropriation to maintain current staffing levels of FY 1991
$ Payroll increase of $546 million
Inflation
$ Inflation costs of $250 million

Facility Activations
$ $50 million

AIDS
-Augment VSOs' FY 1991 current services budget to better accommodate current workload levels
$ $52.5 million increase

Special Pay
-Provide additional funding for special pay legislation
$ $50 million

TABLE 6
Strengthening Medical Care Programs

Program Balance and Flexibility
-Optimize use of efficient health care delivery modalities
-Maintain flexibility of program mix and workload targets
-Heed growing demands of aging populations
-Consider advances in medical technology to provide care in least intrusive, most efficient settings

Focus on Non-Institutional Care
-Hasten adaptation of non-institutional environments

Achieving Targets
-Meet workload targets specified in Table 21 on page 83.

Hospital Inpatients
-Hold hospital inpatients treated constant

Outpatients
-Expand outpatient care to 23.8 million staff visits
$ $215 million in FY 1992

Multi-Layered Long Term Care Facility
-Convert a secondary care facility in each medical region to a long-term and geriatric care center
$ No incremental funding recommended

TABLE 6 (continued)
Strengthening Medical Care Programs

Nursing Homes
VA Nursing Homes
-Increase VA-operated nursing home census to 16,180 in 1992, adding 2000 FTEEs
$ $235 million in FY 1992

Community Nursing Home
-Increase community operated homes' average daily census to 14,600 in 1992
$ $70 million in FY 1992

State Nursing Home
-Increase state veterans nursing homes' average daily census to 11,221 in 1992
$ $.5 million in FY 1992

Geriatric Evaluation and Management Units (GEM)
-Increase number of GEMs from 103 to 172
$ No additional funding required

Geriatric Research, Education, and Clinical Programs (GRECC)
-Increase the number of GRECCs from 15 to 19
$ $12 million in FY 1992

Home Care, Respite and Hospice
Hospital-Based Home Care (HBHC)
-Continue to expand HBHC programs from 72 to 172
$ $33 million in FY 1992

Respite Care
-Establish Respite Care Program at each VAMC
$ No additional funding required

Hospice
-Establish Hospice capacity at each VAMC
$ No additional funding required

Adult Day Health Care (ADHC)
-Increase VA and contracted ADHC programs from 39 to 73
$ $10 million in FY 1992

Community Residential Care
-Establish CRC Programs at each VAMC
$ $3.2 million in FY 1992

Homeless Veteran Programs
-Expand services in metropolitan areas unserved or underserved by the homeless programs
$ $5 million in FY 1992

Post-Traumatic Stress Disorder (PTSD)
-Provide funding to expand facilities specifically designated for the treatment of PTSD
$ $7.25 million in FY 1992

TABLE 6 (continued)
Strengthening Medical Care Programs

Long-term Psychiatric Hospitals
-Provide funding for increasing the psychiatric capability in hospitals designated for this type of treatment
$ Provide an additional $1 million to monies already appropriated for this purpose in FY 1992

Readjustment Counseling
-Re-introduce legislation to provide readjustment counseling to all veterans

AIDS
-Increase funding to meet higher demands
$ $52.5 million added to current services budget

Programs for Blinded Veterans
-Provide funds to maintain excellence of rehabilitation program
$ $1.5 million for 37 FTEEs in FY 1992

Prosthetics and Sensory Aids Service
-Provide funding for increased staffing
-Augment funding for prosthetic equipment and supplies
$ Provide an additional $4 million and 50 FTEEs in FY 1992

Beneficiary Travel
-Provide travel benefits to veterans in order to ensure accessibility

TABLE 7
Strengthening the Medical Care System

National Survey and Catchment Study
-Develop a survey to provide a comprehensive analysis of the unserved veteran population
-Study the cost of expanding Category A entitlement to cover all levels and kinds of VA medical care in a given catchment area

VA's Health Care System Planning
-Reinforce mission and workload targets for each VA facility
-Fund each facility according to mission and assigned workload
-Centralize control of the number and geographic location of high-cost programs
-Track new regional initiatives and their costs
-Report on activations

Information Resources Management (IRM)
-Continue development of the Decentralized Hospital Computer Programs under IRM leadership
-Adequately fund and oversee IRM
- Integrate and modernize Automated Data Porcessing (ADP)

Evaluating the Quality of VA Medical Care
-Provide resources and professional staff to maintain data bases to support this effort

Entitlement to VA Health Care Services
-Provide all Category A veterans with clear entitlement to all types and levels of care in the VA health care system

TABLE 7 (continued)
Strengthening The Medical Care System

Medical Care Appropriation Support
-Ensure appropriation support of all medical entitlement programs

Medical Care Construction Program
-Establish a logical system for setting national construction priorities
-Designate a single VA entity to be accountable for construction projects
-Plan design and construction using guidelines established at national level guided by ideals of quality in patient care and clear, realistic missions for each facility
-Keep timely and accurate inventory of capital facilities

Human Resources Development
Employee Welfare and Morale
-Support continued efforts of VHSRA's Office of Health Care Staff Development and Retention (OHCSDR)
Staffing shortages
Nursing Staff
-Continue interest in legislation involving improved VA nurse pay scale and increased nurse educational opportunities
Physician Staff
-Retain physician staff through special incentive pay already appropriated, but not authorized
Physicians' Assistants
-Reassess utilization and roles of physician assistants
-Develop strategies for recruitment and retention
Education and Training
Increment support for maintaining standards of Graduate Medical Education Programs
-Continue to meet standards by limiting working hours per week to eighty
-Conform to standards of resident supervision
-Add resources to accommodate limited residency hours and resident supervision
$ $132 million for 2,338 FTEEs in FY 1992
Residents/Fellowships
-Increase training opportunities for high demand specialties
$ 10 million for 160 FTEEs
Tuition Reimbursement Program
-Offer tuition reimbursement for 750 VA employees seeking associate degrees in nursing
$ 1.5 million
Career Field and Service Chief Development
-Ensure professional growth of skilled staff for 20,000 episodes of training
$ 10 million
AIDS Training
-Add resources for increased training
$ 3 million

Medical Malpractice
-Modify Federal Tort Claims Act to exempt contract physicians practicing in VA hospitals from tort liability for medical malpractice

Bed and Staffing Levels
-Ensure appropriateness of assigning personnel floors to medical centers
-Reduce and realign personnel in centers not requiring additional personnel

Sharing Agreements
-Encourage appropriate resource-sharing projects and joint ventures with DoD health care facilities

TABLE 7 (continued)
Strengthening the Medical Care System

Pharmaceutical Unit Dose Program
-Complete unit dose implementation in all hospitals by 1995

Decentralized Hospital Computer Program (DHCP)
-Provide all VA medical centers with state-of-the-art computer systems by 1995 starting with the provision of 30 computers in FY 1992
-Provide funding for 100 FTEEs in FY 1992
$ $14.5 million

Equipment Backlog
-Replace outdated and worn equipment in all VA medical facilities by 1995
$ $100 million

TABLE 8
Medical and Prosthetic Research

General
-Provide funding increments to keep up with inflation
$ $259.7
-Increase VA research appropriation to eliminate the necessity for the annual transfer of funds from DoD
$ $20 million
-Maintain flexibility in FTEE levels for research employment
Total $ $279.7 million

Medical Research
-Restore adequate funding levels
-Fund additional research projects in the following increments:
    -Psychoses research $1 million
    -Spinal Cord Regeneration research $1 million
    -AIDS research $1 million
Total $ $3 million increment in FY 1992

Health Services Research
Conduct studies on realignment options of VA health system and to assess impact of mandatory state health insurance programs on the utilization of VA hospitals

TABLE 9
Medical Administration and Miscellaneous Operating Expenses

Current Services
-Establish Central Office service capacity at FY 1988 level
$ $55 million

TABLE 10
Health Professional Scholarship Program

Physician Recruitment
-Recruit physicians at the medical school level utilizing this program
$ $5 million

TABLE 11
Grants for Construction of State Extended Care Facilities

State Home Expansions
-Provide grants for construction to increase nursing home capacity
$ $70 million

TABLE 12
Grants to the Republic of the Philippines

Veterans' Memorial Medical Center
-Replace and upgrade medical equipment
-Rehabilitate physical plant and facilities
$ $500,000

Table 13
Construction Programs

Major Construction	
-Permit more expeditious project planning through the Advance Planning Fund and Design Fund	**$** $44.1 million
-Construct four new 120-bed VA nursing homes	**$** $33.6 million
-Acquire land for two new national cemeteries	**$** $6.6 million
-Complete other Five-Year Plan construction projects	**$** $615.3 million
Minor Construction	
-Complete updating and repair work and other necessary medical construction	**$** $197 million
-Convert 2,500 hospital beds to nursing home beds	**$** $56 million
-Support existing national cemetery construction projects	**$** $10.8 million
-Support VA regional offices	**$** $5.5 million
-Permit staffing at current levels	**$** $63 million
-Provide annual increment for nursing home bed conversion	**$** $20 million
Parking Garage Revolving Fund	
-Finance facility parking garage construction and operation	**$** $25 million

TABLE 14
VA Appropriations By Account
(dollars in thousands)

	1990 Appropriation	1991 Appropriation	1991 IB Current Services*	1992 IB Current Services*	1992 IB Recommended Appropriation
GENERAL OPERATING EXPENSES (GOE) AND MISCELLANEOUS					
General Operating Expenses**	$811,150	$902,514	$902,514	965,083	976,583***
Grants for the Construction of State Veterans Cemeteries	4,288	3,946	3,946	4,112	4,112
Office of the Inspector General	21,306	24,859	24,859	25,903	25,903
Reimbursements					(142,721)
TOTAL GOE AND MISCELLANEOUS	$836,744	$931,319	$931,319	$995,098	$863,877
BENEFITS PROGRAM					
Compensation, Pension, and Burial Benefits	$15,365,495	$15,684,451	$15,684,451	15,209,420	15,209,420
Readjustment Benefits	497,813	502,500	502,500	635,400	635,400
Veterans Insurance and Indemnities	13,940	15,410	15,410	25,740	25,740
Veterans' Job Training Fund	0	0	0	0	0
Loan Guaranty Revolving Fund	313,500	670,700	670,700	373,100	373,100
Guaranty and Indemnity Fund	--	80,800	80,800	74,200	74,200
Credit Reform Costs	--	--	--	635,000	635,000
TOTAL BENEFITS PROGRAMS	$16,190,748	$16,953,861	$16,953,861	16,952,860	16,952,860
MEDICAL PROGRAMS					
Medical Care	$11,325,706	$12,310,490	$12,919,600	$14,020,600	$14,889,850
Medical and Prosthetic Research	212,652	216,795	245,800	279,700	282,700
Medical Administration and Miscellaneous Operating Expenses	45,397	41,434	53,030	55,550	55,550
Health Professional Scholarship Program	--	10,113	--	5,000	5,000
Grants for Construction of State Extended Care Facilities	41,349	70,000	42,000	70,000	70,000
Grant to the Republic of the Philippines	492	484	500	500	500
TOTAL MEDICAL PROGRAMS	$11,625,596	$12,649,316	$13,260,930	$14,431,350	$15,303,600
CONSTRUCTION PROGRAMS					
Construction, Major Projects	408,542	580,000	580,000	580,000	699,600
Construction, Minor Projects	111,937	130,640	130,640	130,640	352,300
Parking Garage Revolving Fund	28,543	28,900	28,900	28,900	25,000
TOTAL CONSTRUCTION PROGRAMS	$549,022	$739,540	$739,540	$739,540	$1,076,900
TOTAL APPROPRIATION	$29,202,110	$31,274,036	$31,885,650	$33,118,848	$34,197,237

*Funds necessary to maintain services at the FY 1988 level.

**Independent Budget figures do not include major appropriations items such as ADP and non-ADP equipment purchase and maintenance.

***See Table 17 on page 61 for explanatory notes.

LEGISLATIVE PROPOSALS

The Independent Budget recommends the enactment of legislation which would improve a variety of VA health care and benefit programs. A detailed description of our proposals is contained in the text pages of this document. In brief, the enactment of these initiatives would:

- Establish the period beginning on August 2, 1990, as period of war for Title 38, United States Code purposes.
- Increase the maximum face value of Veterans' Mortgage Life Insurance (VMLI) policies from $40,000 to $90,000.
- Provide the availability of $10,000 supplemental life insurance for Service Disabled Veterans' Insurance (SDVI) policy holders who have waiver of premiums in effect.
- Increase the maximum limitations on VA's Home Improvements and Structural Alterations (HISA) grants from $2,500 to $5,000 for service-connected veterans and from $600 to $1,200 for non-service-connected veterans.
- Require VA to provide for the payment, on an interim basis, of compensation, Dependency and Indemnity Compensation (DIC), and pension benefits to veterans and their survivors/dependents if their claims for such benefits are not decided within established time limits.
- Require VA to arrange vocational rehabilitation services for eligible disabled veterans by accredited non-VA agency if VA is unable to provide such services on a timely basis.
- Provide Category A veterans with entitlement to the full array of VA health care services—inpatient hospital, outpatient, long-term and nursing home care.
- Mandate the establishment of a veterans' cemetery in every state.
- Require specific appropriation support for any VA medical programs for veterans who meet eligibility requirements in accordance with Congressionally-mandated entitlements.
- Expand programs to provide improved inpatient and outpatient treatment for veterans suffering from PTSD.
- Provide program enhancements for the homeless.
- Provide the total exemption from sequestration of VA's Medical Care account.
- Expand eligibility for readjustment counseling and follow-up mental health care to include veterans of service in theaters of operations of any prior periods of war and veterans of service in areas in which United States personnel were subjected to danger from armed conflict comparable to that of battle with any enemy during a period of war.
- Establish a pilot program to assess veterans' unmet needs for medical care through a national survey and catchment study.
- Provide appropriate pay increases for VA physicians and dentists.

The VSOs' Deficit Reduction Plan is discussed in detail in the following pages. The plan includes support for VA's General Operating Expenses (GOE) account through the Loan Guaranty Revolving Fund and Compensation/Pension Benefits Programs. The following legislative proposals, in brief, constitute critical elements of that plan and include the repeal of fourteen provisions of Title VIII of the Omnibus Budget Reconciliation Act of 1990 (OBRA).

Repeal the following provisions of OBRA 1990 which amend Title 38, United States Code and the Internal Revenue Code of 1986:

- Section 8001. Limitation on Compensation for Certain Incompetent Veterans.
- Section 8002. Elimination of Presumption of Total Disability in Determination of Pension for Certain Veterans.
- Section 8003. Reduction in Pension for Certain Veterans Receiving Medicaid-Covered Nursing Home Care.
- Section 8004. Ineligibility for Reinstatement of Benefits for Remarried Surviving Spouses or Married Children Upon Becoming Single.
- Section 8012. Co-Payment for Medication.
- Section 8013. Modification of Health Care Categories and Co-Payments.

- Section 8021. Limitation of Vocational Rehabilitation Program Entitlement to Service-Disabled Veterans Rated at 20 Percent or More.

- Section 8032. Increased VA Loan Fees.

- Section 8041. Elimination of Headstone or Marker Allowance.

- Section 8042. Limitation of Plot Allowance Eligibility.

- Section 8051. Under the amendments to Subparagraph (D) of section 6103 (1)(7) of the Internal Revenue Code of 1986, repeal the phrase, "or any other law administered by the Secretary of Veterans Affairs," contained in (c)(viii)(I). Under the amendments to section 3117, Chapter 53, title 38, USC, repeal subsection (d), GAO Study.

- Section 8052. Line of Duty—Secondary Effects of Willful Misconduct.

- For the purposes of VA's Home Loan Program, require VA to consider the value of resale losses when determining whether or not to acquire a foreclosed property.

[redacted]

BENEFITS PROGRAMS
Principles and Guidelines

- Among federal benefits programs, Congress has subjected Veterans Benefits Programs alone to entitlement cuts, for purposes of deficit reduction. This is neither fair nor necessary.

- Entitlement cuts should be enacted only after full and fair debate, which includes a recognition of a program's purpose and intent. For example, the Compensation Program is the nation's tangible commitment to veterans disabled during military service. Unless Congress explicitly alters that commitment, program cuts under the guise of deficit reduction is not a legitimate way of doing legislative business. Moreover, "robbing Peter to pay Paul" by cutting one veterans' program to fund another damages the integrity and effectiveness of veterans' programs as a whole.

- The deficit reduction targets of the Omnibus Budget Reconciliation Act of 1990 (OBRA) can be met and substantially exceeded without any entitlement cuts.

- Benefits Programs spending at less than the inflation rate can and should be scored as savings credited toward deficit reduction under OBRA.

- During FYs 1991-1995, normal attrition in compensation and pension rolls, efficient third-party medical care cost recoveries, VA access to Internal Revenue Service and Social Security Administration data for legitimate program purposes, and administrative and program reforms in the Home Loan Guaranty Program will produce savings substantially exceeding OBRA's deficit reduction targets.

- Savings in excess of deficit reduction targets should be retained for use by VA and invested in improving health care and benefits and service delivery to veterans.

BENEFITS PROGRAMS

The Department of Veterans Affairs (VA) administers veterans' benefit programs through funding provided by the General Operating Expenses (GOE) appropriation. These benefit programs include more than a dozen appropriations and revolving fund accounts. Most are self-financing or funded by other government departments (principally by the Department of Defense) and require no VA appropriations. Benefit accounts requiring VA appropriations treated in this Independent Budget are:

- o Compensation and Pensions (C&P).
- o Readjustment Benefits (RB).
- o Veterans Insurance and Indemnities (VI&I).
- o Loan Guaranty Revolving Fund (LGRF).

Benefit payments from these accounts result from determinations that veterans, their dependents and survivors meet eligibility requirements set by law. When veterans meet those requirements, benefit payments are non-discretionary, which means the government is obligated to pay them. Appropriations for these accounts are based on estimates of the number of individuals who will be entitled to benefit payments under these programs during the fiscal year. VA is usually in the best position to make accurate estimates. If the estimates are low, Congress enacts a supplemental appropriation.

Veterans Benefits Programs are now major deficit reduction targets.

For FY 1992, it will be particularly difficult for VA to make an accurate appropriations estimate because of the uncertain impact of enacted deficit reduction legislation. Previous Independent Budgets deferred to VA's estimates; however, the VSOs have a number of legislative recommendations for Benefits Programs which will affect appropriations for these accounts. Table 15 compares FY 1991 Benefits Programs enacted appropriations with VA's FY 1992 budget request and provides the baseline for the VSOs' legislative recommendations.

In previous Independent Budgets, Benefits Programs were covered after General Operating Expenses (GOE) simply because GOE was where the budgetary action and problems were. Benefits Programs, being entitlements authorized by Congress, were essentially beyond the budget-cutters' reach; funding for them was nondiscretionary. Problems in the Benefits Programs area—for example, large and continuing Loan Guaranty Revolving Fund deficits—were not so much associated with the programs themselves but with VA's administration and delivery of them, subjects more appropriately discussed with GOE.

The budget-cutters' axe traditionally targeted the discretionary GOE account, and, accordingly, the VSOs' primary concern was to show the effects of GOE cuts on service to veterans. The VSOs demonstrated this priority by discussing GOE before Benefits Programs.

With the recent passage of deficit reduction legislation, however, the budget process has suddenly and dramatically turned on its head. Veterans Benefits Programs (that is, entitlements), for years on every frustrated budget-cutter's unattainable wish list, are now major deficit reduction targets. Within a year, what had been politically unthinkable has become the new budgetary reality. The Independent Budget must recognize the new reality; therefore, in this year's Independent Budget, Veterans Benefits Programs are being discussed first.

As part of the deficit reduction package, Congress has enacted legislation that is expected to produce savings of $620 million in FY 1991 and $3.7 billion over the next five years. The fact of this legislation and the enormity of the program cuts are startling; perhaps even more surprising is the speed and facility with which it was enacted. The VSOs fear that the ease with which veterans' entitlements have been cut may embolden Congress and that such legislation will not be a one-time occurrence.

The Independent Budget's purpose is to provide Congress with the VSOs' views on all aspects of veterans' programs, including their adequacy and the manner in which VA is delivering them to veterans and their dependents. The Independent Budget, of course, is not the only forum for this; the VSOs routinely are asked to provide their views at Congressional hearings on matters affecting veterans, and there is frequent informal communication between VSOs and members of Congress and their staffs. The Independent Budget, however, has become the best means for thoroughly expressing the VSOs' positions, assessing the performance of VA and Congress from the perspectives of veterans; and making recommendations that detail rationale support for improving veterans' programs and services and their delivery.

TABLE 15
Benefits Programs
(dollars in thousands)

	FY 1991 Enacted Appropriations	FY 1992 VA Budget Request
Compensation and Pensions	$15,684,451	15,209,420
Readjustment Benefits	502,500	635,400
Veterans Insurance and Indemnities	15,410	25,740
Loan Guaranty Revolving Fund	670,700	373,100
Guaranty and Indemnity Fund	80,800	74,200
Total Benefits Programs	$16,953,861	16,317,860*

*Does not include OBRA credit reform costs of $635 million.

Congress has repeatedly praised the Independent Budget, precisely for providing this kind of comprehensive and thoughtful analysis by the veterans who receive authorized benefit programs. The Independent Budget has served as an effective counterpoint by revealing the true state of VA's delivery of health care and benefit programs and services to veterans, and the budgetary resources needed to restore good service to veterans. In doing so, the Independent Budget has had a significant influence in reversing budget cuts that had crippled VA's ability to provide adequate veterans' health care, benefits, and services. The Independent Budget thus provided Congress an essential frame-of-reference for responsible budgetary decisions within a climate of fiscal austerity.

The point is that the kind of input the Independent Budget provides was absent in the process that produced the deficit reduction package as it affects Veterans Benefits Programs. The interminable length of the Budget Summit negotiations, the Congressional rejection of the Summit package, the scurrying about for an alternative plan that could be enacted, the political posturing, government shutdowns and threats of worse to follow, created an environment that neither invited nor permitted sober analysis of what was being done and, just as importantly, what it means for the future.

The budget process has taken an historic turn in the name of deficit reduction, and perhaps at no time has it been more important for the VSOs to offer their counsel to Congress and to make our position as clear as possible. Only now is it possible to analyze what Congress has done and, accepting the reality of deficit reduction, ask the question: Is there a better way?

Table 16 summarizes all budget reconciliation deficit reduction provisions. Most directly affect Benefits Programs, and we will analyze each provision under the applicable Benefit Programs account discussion. Following these analyses, the VSOs will assess the deficit reduction legislation as a whole and offer alternatives, which we believe will be at least as effective in reducing the deficits but more fair and considerably less harmful to veterans and their dependents.

In analyzing these provisions and suggesting alternatives, however, the VSOs are guided by two basic principles:

1. Cuts or modifications in Benefits Programs for deficit reduction purposes should not change in any way the fundamental and intended purpose of affected programs. For example, Pensions is a needs-based program; Compensation is *not*.

2. Congress should not view cuts in veterans' entitlements in isolation but within the context of other federal benefit programs. Veterans, especially service-connected disabled veterans, have a unique status. Congress certainly should not require them to pay an inordinate price for reducing the deficit.

TABLE 16
Omnibus Budget Reconciliation Act of 1990
Deficit Reduction Provisions - Title VIII—Veterans' Programs

PROVISION	Savings (millions of dollars) FY 91	FYs 91-95
Compensation, DIC and Pension		
Section		
8001 - Compensation benefits for certain incompetent veterans (sunsets 9/30/92)	$125	$291
8002 - Elimination of presumption of total disability in determination of pension for certain veterans	17	313
8003 - Reduction in pension for certain veterans receiving Medicaid - covered nursing home care (sunset 9/30/92)	22	124
8004 - Ineligibility of remarried surviving spouse or married children for reinstatement of benefits eligibility upon becoming single	19	374
8005 - Cost-of-living increases in compensation rates	49	49
Health Care Benefits		
8011 - Medical-care cost recovery (sunsets 9/30/93)	113	826
8012 - Co-payment for medication (sunsets 9/30/91)	66	85
8013 - Modification of health care categories and co-payments (sunsets 9/30/91)	35	45
Education and Employment		
8021 - Limitation of rehabilitation program entitlement to service disabled veterans rated at 20 percent or more	20	180
Housing and Loan Guaranty Assistance		
8031 - Election of claim under guaranty of manufactured home loans	4	14
8032 - Loan fee (sunsets 9/30/91)	79	79
Burial and Grave Marker Benefits		
8041 - Headstone or marker allowance	3	19
8042 - Plot allowance eligibility	27	147
Miscellaneous		
8051 - Use of Internal Revenue Service and Social Security Administration data for income verification	28	743
8052 - Line of duty (Secondary effects of willful misconduct)	10	334
8053 - Requirement for claimants to report social security	4	47
TOTAL	$621	$3,670

COMPENSATION AND PENSIONS

The Compensation and Pensions appropriations provide funds for compensation, pension, and burial benefits, and also some miscellaneous benefits.

Compensation: Compensation is paid to veterans for disabilities incurred during active military service or aggravated during service. Dependency and Indemnity Compensation (DIC) is paid to survivors of servicepersons or veterans whose deaths occurred while on active duty or as a result of service-connected disabilities. The rate payable depends on degree of disability (for living veterans), service rank (for survivors of veterans), and number of dependents for both veterans and survivors. In addition, a clothing allowance is provided for service-connected disabled veterans who use a prosthetic or orthopedic appliance that tends to wear out clothing.

Pensions: Pension benefits are paid to aged (65 or older) veterans who were receiving benefits prior to November 1, 1990, or disabled veterans of wartime service who have low income, and to their survivors. (There is no disability requirement for survivors.) Amounts payable depend on income and number of dependents. Pensioners who have come on the rolls since January 1, 1979, receive "improved law" pensions that include an automatic annual COLA increase equal to the Social Security COLA, count almost all income in determining income for pension eligibility, and reduce pension amounts dollar-for-dollar for every dollar of income from other sources. More than half of pensioners and more than four of every five pension dollars are paid under the improved law program. Older pension programs have major income disregards, little or no pension reduction for income from other sources, and no automatic annual increases.

Burial Benefits and Miscellaneous Assistance: The Burial Benefits program provides for (a) the payment of an allowance of $300 (plus transportation charges where death occurs under VA care) to reimburse, in part, the burial and funeral expenses of an eligible deceased veteran; (b) the payment of an allowance of $150 for a plot allowance where an eligible veteran is not buried in a national cemetery or other cemetery under the jurisdiction of the United States (for deaths occurring before December 1, 1990); (c) the payment of a burial allowance up to $1,500 when a veteran dies as the result of service-connected disability; (d) a flag to drape the casket of each entitled deceased veteran entitled thereto; (e) a headstone or marker for the veteran and, in certain cases, eligible dependents; (f) an allowance towards the headstone purchase (for deaths occurring before December 1, 1990); (g) authority to provide graveliners for certain veterans interred in the National Cemetery System; and (h) funds to reimburse the General Operating Expenses appropriation for administering the Arizona Veterans Memorial Cemetery.

Miscellaneous Assistance: Miscellaneous Assistance serves to meet the needs of a select group of servicepersons, veterans and survivors, and provides for the following:

Retired Officers Benefits: Emergency officers of World War I and certain other officers who have retired because of service-connected disabilities are entitled to special benefits.

Adjusted Service and Dependency Pay: Claims made pursuant to the provisions of The World War Adjusted Compensation Act of 1924, as amended.

Special Allowance for Dependents: Under certain conditions, a special allowance is payable to dependents of certain veterans who died after December 31, 1956, but who were not fully and currently insured under the Social Security Act (38 U.S.C. 412).

Mortgage Insurance: Mortgage protection life insurance (up to $40,000) for service-connected disabled veterans who have received grants for special adapted housing. Effective September 1, 1988, Public Law 100-322 authorized the funding for this program from the Veterans Insurance and Indemnities appropriation.

ANALYSES OF DEFICIT REDUCTION PROVISIONS AFFECTING COMPENSATION AND PENSIONS

Throughout the seemingly unending budget debate, the one constant has been elected officials' insistence that deficit reduction be fair. On the spending side this means that similarly-situated beneficiaries of federal entitlement programs should not be treated differently. If entitlement cuts are necessary, they should apply to programs "across-the-board". The latest version of deficit reduction singles out Veterans Benefits programs for entitlement cuts and, in so doing, mocks the often-espoused but seldom-practiced principle of fairness.

Not only have non-veteran federal entitlement programs escaped cuts, Congress has expanded and enhanced many of them—for example, Medicaid and Social Security—at a cost of hundreds of millions of dollars. The VSOs ask our friends in Congress: Why and how did this happen, and what groups or special interests benefited from the dollars taken from veterans and their dependents? It is indeed ironic that this occurred during Operation Desert Shield, when hundreds of thousands of members of the military, including thousands of citizens called to active duty, have been sent halfway around the world to put their lives on the line to defend our nation's interests. Veterans can only feel a deep sense of betrayal and, for Congress's enlightenment, the VSOs would like to explain why in some detail.

The most objectionable aspect of the enacted deficit reduction package is the way it isolates Veterans Benefits programs for major cuts without justification. The gross unfairness of this will be illustrated by comparing the affected Veterans Benefit programs with their entitlement counterparts in other programs, primarily those administered by the Social Security Administration.

COMPENSATION

Compensation is similar to Social Security Old Age, Survivors, and Disability Insurance Benefits (OASDI) in that entitlement is neither needs-based nor means-tested. Compensation is paid only for service-connected disabilities with the percentage of disability determined according to a rating schedule. Social Security Disability Insurance Benefits (DIB) are paid to individuals whose impairments prevent them from performing substantial gainful activity, considering their age, education and past work experience. Compensation and DIB payments are suspended if the individual is convicted of subversive activities or incarcerated for conviction of a felony.

Under the deficit reduction legislation, benefits to service-connected disabled veterans and their survivors have been affected significantly, but there has been no corresponding impact on Social Security beneficiaries. For example:

Compensation Paid to Certain Incompetent Veterans

This provision applies to incompetent veterans having neither spouse, dependent child, nor dependent parent, whose estates, excluding the value of the veterans' homes, exceed $25,000. For these veterans, compensation payments may not be made until the value of the estate is reduced to less than $10,000.

Projected savings from this provision, which expires on September 30, 1992, are $125 million for FY 1991 and $291 million for FYs 1991-1995.

This provision is directed at the most vulnerable and disabled of all compensation recipients. It imposes a means test on individuals who have lost their most valuable possessions—that is, their cognitive faculties—often as a result of combat injuries. It applies only to those veterans who do not have a spouse, dependent child or dependent parent—a truly odd distinction. What about a non-dependent parent or child, a brother or sister or niece or nephew, who cares for the incompetent veteran at great personal sacrifice?

It is doubtful that this disparate treatment of the most vulnerable compensation recipients—that is, imposing a means test on only them—will withstand a likely judicial challenge. Congress can rectify the situation by immediately repealing this provision of the deficit reduction package.

Alternately, if Congress believes this provision is legitimate, it should apply it to the widest possible base. Projected savings from this two-year provision are $291 million. If Congress can justify applying this provision to compensation recipients, it should have no philosophical inhibition to applying it to all incompetent Social Security OASDI recipients—that is, those who have representative payees. If $291 million can be saved by not paying incompetent veterans, think of the savings that could result from not paying incompetent Social Security beneficiaries.

By way of comparison, there are approximately 117,000 incompetent veterans whose benefits are paid to fiduciaries on their behalf, but there are 3,334,312 representative payees (as of September 30, 1989) who receive non-means tested benefits on behalf of Social Security OASDI beneficiaries. Enacting a similar OASDI provision, however, is unlikely, because the Omnibus Budget Reconciliation Act of 1990, which contains the provision designed to result in the nonpayment of $291 million in compensation to incompetent service-connected disabled veterans over a two-year period also contains provisions for comprehensive reforms of the Social Security representative payee system. These reforms are designed to enhance the rights of OASDI incompetent beneficiaries and ensure that all their benefits are used in their best interests. These protections apply to all without regard to the size of their estates or the number or remoteness of their living relatives. (See Title V, Subtitle B, Section 5105 of the Omnibus Budget Reconciliation Act of 1990).

As a practical matter, it is observed that implementation of this provision will fall to the Veterans Services component of the Veterans Benefits Administration (VBA). As pointed out in the FY 1991 Independent Budget, however, Veterans Services is so understaffed, that in 1988, 1.7 million veterans who attempted to contact Veterans Services by phone were unable even to talk to a veterans benefits counselor. Staff hours for outreach activities have decreased 40 percent since 1985, and no veterans benefits counselors are available for face-to-face interviews in 24 of the country's 75 largest metropolitan areas. Yet, Veterans Services will have the unwelcome task of stopping compensation payments to incompetent veterans and tracking the value of their estates.

Although Congress has devised an innovative method for funding administrative costs of this and other deficit reduction provisions (which we will discuss later), the VSOs are concerned that the highest priority for VBA resource use will be for deficit reduction purposes, rather than answering veterans' calls or providing outreach activities for needy veterans.

Here, too, a comparison of the Budget Reconciliation Act provisions affecting Social Security is apt. Title V, Subtitle B, Section 5110 of the Act requires the Social Security Administration (SSA) to maintain access by telephone to local offices, in addition to the service provided by telephone service centers via the national 800 number. Subtitle B, Section 5108 requires SSA to conduct demonstration projects (in not fewer than three telephone service centers) relating to accountability of telephone service center communications. It is interesting to compare the level of service Congress expects SSA to provide the public with the level of service VA is actually providing to veterans. With respect to accountability procedures, Section 5108 provides:

> ACCOUNTABILITY PROCEDURES
>
> (1) In General -- During the period of each demonstration project developed and carried out by the Secretary of Health and Human Services with respect to a telephone service center pursuant to subsection (a), the Secretary shall provide for the application at such telephone service center of accountability procedures consisting of the following:
>
> (A) In any case in which a person communicates with the Social Security Administration by telephone at such telephone service center and provides in such communication his or her name, address, and such other identifying information as the Secretary determines necessary and appropriate for purposes of this subparagraph, the Secretary must thereafter promptly provide such person a written receipt which sets forth--
>
> (i) the name of any individual representing the Social Security Administration with whom such person has spoken in such communication,
>
> (ii) the date of the communication;
>
> (iii) a description of the nature of the communication,
>
> (iv) any action that an individual representing the Social Security Administration has indicated in the communication will be taken in response to the communication, and
>
> (v) a description of the information or advice offered in the communication by an individual representing the Social Security Administration.
>
> (B) Such person must be notified during the communication by an individual representing the Social Security Administration that, if adequate identifying information is provided to the Administration, a receipt described in subparagraph (A) will be provided to such person.
>
> (C) A copy of any receipt required to be provided to any person under subparagraph (A) must be --
>
> (i) included in the file maintained by the Social Security Administration relating to such person, or
>
> (ii) if there is no such file, otherwise retained by the Social Security Administration in retrievable form until the end of the 5-year period following the termination of the project.

Thus, while SSA must document in writing what transpires during a telephone inquiry, send a copy to the inquirer and maintain a record of it for five years, more veterans will be unable even to contact VA by telephone (much less have local access to a veterans' benefits counselor) because VA employees will be diverted to ascertaining the value of incompetent, service-connected disabled veterans' estates so they can stop making compensation payment to them.

Prohibit Payment of Compensation for Secondary Effect of Willful Misconduct

This provision's projected savings are $10 million in FY 1991 and $334 million for FYs 1991-1995.

The VSOs believe that either all or none of the applicants for federally-administered disability programs should be subject to this kind of deficit reduction provision. We find it particularly objectionable that this provision applies only to service-connected compensation; it does not apply to Pensions applicants or the far more numerous Social Security disability applicants. As with the provision relating to nonpayment of benefits to incompetent veterans, applying the secondary effects of willful misconduct standard to Social Security and Supplemental Security Income disability applicants would yield greatly increased savings to be applied to deficit reductions.

Repeal Benefit Restoration Eligibility for Remarried Spouses and Married Children

Projected savings from this provision are $19 million for FY 1991 and $374 million for FYs 1991-1995.

It is important to observe that, compared with other federally-administered retirement and survivors programs, *the remarriage provision being repealed was already the most restrictive*. If a veteran's surviving spouse remarried (remarriage included holding out oneself openly as the third person's spouse without benefit of ceremony) the surviving spouse became ineligible for DIC or needs-based pension. Upon termination of the remarriage, the surviving spouse could regain eligibility.

This departs markedly from other benefit programs. Under Social Security, for example, a surviving spouse who is age 60 or older may remarry with *no* restrictions on his or her entitlement or eligibility for benefits. Individuals who are at least age 50 and who meet the disability requirements for widows'/widowers' benefits at the time of remarriage can receive benefits as a surviving spouse, even though remarried. Under the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS), surviving spouses may remarry after they reach age 55 with no effect on their annuity eligibility.

An illustration of the inequity of deficit reduction to veterans and their dependents is the fact that, as the House and Senate Veterans Affairs Committees drafted legislation to make remarriage a permanent bar to survivors' benefits eligibility, the House and Senate Select Intelligence Committees drafted legislation to liberalize the remarriage provisions under the CIA Retirement and Disability System's (CIARDS) to *"conform these provisions of CIARDS to similar provisions applicable to the Civil Service Retirement System, the Foreign Service Retirement System, and the Federal Employee Retirement System"*. (Quote is from the Report on the Intelligence Authorization Act for Fiscal Year 1991-H.R. 5422 (Report 101-725, p.13)). The CIARDS legislation *lowers* from age 60 to 55 the age before which a surviving or former spouse's entitlement shall terminate based upon remarriage. Moreover, under CIARDS, former spouses whose benefits were terminated because of remarriage before the age of 55 have their benefits restored upon termination of the remarriage. Prior legislation had provided for the restoration of benefits to former spouses who were divorced after November 15, 1982, again to "provide greater consistency with other federal retirement programs." (Rept. 101-725, p.14)

The VSOs believe that the surviving spouses of veterans, especially the surviving spouses of veterans who died in combat or as a result of service-connected disabilities, should not be singled out for deficit reduction. We therefore call for the repeal of the provision of OBRA that restricts the restoration of eligibility for remarried spouses and remarried children for DIC benefits.

It also is worth observing that Title V, Subsection B, Section 5103 of the Omnibus Budget Reconciliation Act of 1990 significantly *liberalizes* the disability test for Social Security widows/widowers, while in the same bill Congress forecloses the entitlement of surviving spouses of those who died in combat if the surviving spouses remarry at any age, regardless of their financial status.

PENSIONS

The budgetary axe fell heavily on veterans' pensions, as well. Here, too, Congress has targeted vulnerable veterans—the elderly (those age 65 and over) and pension beneficiaries in nursing homes—by enacting the following provisions:

Eliminate the Presumption of Total Disability at Age 65

Projected savings from this provision are $17 million for FY 1991 and $313 million for FYs 1991-1995.

The Social Security counterpart to the Veterans Pensions Program is Supplemental Security Income (SSI). Both programs are needs-based. Pensions benefits are paid to aged (65 or older) or disabled veterans of wartime service who have low incomes, and to their survivors. SSI benefits are paid to low-income, aged (65 or older) and disabled individuals. Neither program pays benefits to individuals considered able to work; both, however, until now, operated under the presumption that at age 65 individuals are unable to work, that is, they are disabled. This is also the presumption underlying Social Security Old Age (Retirement) Benefits. Social Security disability benefits are paid only to individuals under age 65; at age 65, they are presumed unable to work, regardless of any physical or mental disabilities they may have. Social Security regulations incorporate this principle by requiring less in the way of impairment severity to be found disabled as an individual approaches age 65.

Eliminating the presumption of disability at age 65 for wartime veterans means, as a matter of public policy, that aged wartime veterans are not only considered able to work but are expected to, whereas all other aged individuals are not. Moreover as a practical matter, the VSOs do not believe that the rules for determining disability and unemployability for individuals who are under age 65 can rationally be applied to individuals age 65 and over.

Whether or not a significant number of aged pension applicants will be found not disabled remains to be seen; however, as we will discuss below, it is certain the Pensions program will contribute greatly to deficit reduction throughout the foreseeable future. This being so, it is surprising that Congress eliminated the presumption of disability at age 65 and only for the Veterans Pensions Program.

Reduction in Pensions for Veterans Receiving Medicaid-Covered Nursing Home Care

Under prior law, the pension of a veteran in a nursing home at VA expense who has no dependents is reduced to a maximum of $90 per month after the third month of care. Veterans in nursing homes under Medicaid do not have their pension benefits reduced, but are required to apply their VA pension towards the cost of their nursing home care.

This provision would limit monthly pension payments to $90 for Medicaid-eligible recipients of a VA pension who have no dependents and who are in nursing homes participating in Medicaid—except in the case of veterans who are in state veterans homes. The provision also would prohibit any part of that $90 payment from being applied to the cost of the veteran's nursing home care.

> *It is difficult to believe that Congress can eliminate burial benefits for families of wartime veterans.*

Projected savings from this provision are $22 million for FY 1991 and $124 million for FYs 1991-1995.

Obviously, this provision does not "save" money; it merely transfers costs to the states, who are already financially strapped. It may, however, have unforeseen consequences. Not having full pension benefits to offset the high cost of nursing home care may limit veterans' access to nursing homes. Moreover, 49 of the 50 states must balance their budgets. The increased costs to the states therefore must be offset by service reductions in other areas and/or tax increases.

BURIAL BENEFITS

Prior law provided, in lieu of a VA-provided headstone or gravemarker, for reimbursement (currently $87) for the cost of a headstone or gravemarker for a veteran who is eligible to be, but is not, buried in a national cemetery.

The Omnibus Budget Reconciliation Act of 1990 eliminates this allowance for deaths occurring on or after November 1, 1990. Projected savings from this provision are $3 million for FY 1991 and $19 million for FYs 1991-1995.

Prior law provided for a plot allowance of up to $150 for an eligible veteran who is not buried in a national cemetery or other cemetery under the jurisdiction of the United States.

The Omnibus Budget Reconciliation Act of 1990 eliminates the plot allowance for veterans who die on or after November 1, 1990, whose eligibility is based solely on being a veteran of any war (unless buried in a state veterans cemetery). Projected savings from this provision are $27 million for FY 1991 and $147 million for FYs 1991-1995.

The benefits being eliminated in the name of deficit reduction expressed the country's gratitude to the families of deceased veterans. The combined monetary value of the benefits amounted to at most $237; thus, they were more symbolic tokens than benefits intended to make a significant contribution toward the veteran's burial expenses. In many instances, they were the only benefits the government paid based on the veteran's wartime service and they meant simply that we remember and we are grateful.

Eliminating these benefits means, at best, that this symbolic expression of the country's gratitude is very low among our spending priorities; at worst, it means that we choose not to remember and the veteran's service to his/her country was of no value. It is difficult to believe that Congress can eliminate burial benefits for families of wartime veterans. Before Congress considered cuts in Veterans Benefits programs, it should have eliminated, delayed or pared to the bone grants and pork-barrel projects. Moreover, the VSOs can see no justification for expanding or enhancing non-veteran benefits programs while Veterans Benefits Programs are cut.

THE COLA

A provision for a 5.4 percent COLA for Compensation and DIC recipients was stripped from the Omnibus Budget Reconciliation Act when this provision was held hostage to other legislation. This is nothing less than disgraceful. Veterans with service-connected disabilities and survivors of veterans who died from service-connected disabilities, alone among all federal benefits and retirement programs recipients, did not receive a COLA. Where is the sense of priorities and fairness?

Moreover, the Budget Reconciliation legislation provided for a one-month delay in the COLA payment, which would have been paid retroactively in January 1992. No other benefit or retirement program COLAs were affected in any way. Projected savings from this provision are $49 million for FY 1991.

It is ironic that only the VSOs among advocacy groups have consistently stated that veterans and their survivors would accept a COLA delay or cut, if it were applied across-the-board to other benefit and retirement programs. The veterans' reward for this fiscally-responsible position was to be singled out for a COLA delay. The VSOs again observe that if Congress is truly serious about deficit reduction, it needs only to apply the same philosophy and methods used to cut veterans' programs to analogous federal programs. For example, annual benefit payments for non-means tested Social Security OASDI Benefits are approximately 20 times greater than Compensation and DIC payments. If the same COLA-delay provision that was to be applied to Compensation and DIC were applied to OASDI, the FY 1991 savings would be 20 times greater, or an additional $980 million ($49 million x 20).

Under no circumstances should compensation recipients have their right to privacy violated.

Aggregate projected savings from this litany of direct entitlement cuts (which apply to no non-veteran federal programs) are $272 million for FY 1991 and $1.311 billion for FYs 1991-1995.

OTHER BUDGET RECONCILIATION PROVISIONS AFFECTING THE COMPENSATION AND PENSIONS ACCOUNT

There are two provisions that directly relate to deficit reduction which do not infringe upon or change the basic elements of program entitlement.

Authorizing the Use of Internal Revenue Service and Social Security Data for Income Verification

The House/Senate Veterans Affairs Committee Conference Agreement states:

> Section 11051 would amend paragraph (7) of Section 6103 (1) of the Internal Revenue Code of 1986 so as to require disclosure to VA of (a) such third-party and self-employment tax information for purposes of determining eligibility for VA needs-based pension and parents' dependency and indemnity compensation and VA health-care services based on income status, and (b) only wage and self-employment eligibility for compensation paid (pursuant to Section 4.16 of Title 38, Code of Federal Regulations) at the total-disability-rating level based on an individual determination of unemployability.

The Conference Agreement language specifies the legitimate program purposes for which VA may use the income data. The VSOs support this provision as it is described in the Conference Agreement. This provision, which expires on September 30, 1992, is projected to produce savings of $28 million for FY 1991 and $743 million for FYs 1991-1995. (As we will discuss later, the VSOs believe the projected savings for FY 1991 should be considerably higher.)

The VSOs are concerned, however, that the statutory language may be interpreted as going beyond the scope of the Conference Agreement by adding the phrase, "or any other law administered by the Secretary of Veterans Affairs." This phrase appears in Title VIII, Section 8051 of the Omnibus Budget Reconciliation Act, which amends Section 3117 of Title 38 U.S.C. The VSOs *strongly* object to this added all-inclusive use of IRS and Social Security income data. The *only* legitimate program uses for the data have been identified in the Conference Agreement. Under no circumstances should compensation recipients, whose net worth and earnings from employment are irrelevant to their compensation entitlement, have their right to privacy violated by being subject to this provision. Since no reason has been identified in the Conference Agreement or elsewhere for insertion of the phrase, "or any other program administered by the Secretary of Veterans Affairs," and because it creates great potential for privacy right violations, Congress should strike it from the statute.

The VSOs also observe that Section 3117 calls for a GAO study "of the effectiveness of the amendments made by this section." The Conference Agreement made no mention of a GAO study, and we fail to see the need for one. Certainly the VA's Office of the Inspector General can and will conduct such a study and limit it to legitimate program purposes.

Requiring Claimants to Report Social Security Numbers; Uses of Death Information by the Department of Veterans Affairs

The purpose of this provision is to permit VA to compare its records regarding recipients of compensation and pension benefits with the Social Security Administration's in order to determine whether any recipient of these benefits is deceased. The provision, which is projected to save $4 million for FY 1991 and $47 million for FYs 1991-1995, makes sense, and is supported by the VSOs.

Funding for the Administrative Costs of Implementing Budget Reconciliation Act Provisions

The provisions that are expected to require increased administrative costs (for example, limiting compensation payment for certain incompetent veterans, reducing pension payment for veterans in Medicaid-covered nursing homes, and obtaining income verification and death information from other departments) are to be implemented not from appropriations from the GOE account, but from "amounts available to the Department of Veterans Affairs for the payment of compensation and pension."

What is startling here is the ease with which Congress is making additional FTEEs and non-personnel resources available to implement entitlement cuts and overpayment recoveries. It is unfortunate that this solution did not occur to Congress earlier. In the FY 1991 Independent Budget, the VSOs pleaded for a $25 million increase over FY 1990 appropriations for additional Veterans Benefits Administration FTEEs, which we believed would begin to restore adequate delivery of all nonmedical benefits and services to veterans. (We also pointed out that in FY 1989 this level of service could have been provided at a cost of an additional $10.6 million over the then-current service level.) The recommended $25 million is less than $1 for every living veteran. To put it in the context of the funding mechanism introduced in the Omnibus Budget Reconciliation Act, the additional $25 million that the VSOs requested for FY 1991 represents .0016 percent of the $15,684,551,000 appropriated for compensation and pensions payment for FY 1991. Yet it was virtually impossible to have this relatively insignificant amount appropriated.

The innovative funding device in Budget Reconciliation, however, has opened the appropriations door. If VA can use compensation and pension funds to cut those very entitlements, why can it not use a minuscule portion of them to provide adequate delivery of those entitlements?

READJUSTMENT BENEFITS

FY 1992 appropriations will fund the following Readjustment Benefits programs for veterans and certain eligible dependents and servicepersons.

- o *All Volunteer Force Educational Assistance (veterans):* Chapter 30, Title 38, U.S.C. This program provides educational assistance benefits to veterans whose initial entry to active duty took place after June 30, 1985. The purposes of the program are to assist in the readjustment of members of the Armed Forces to civilian life after their separation from military service, to promote and assist the All-Volunteer Force program and to aid the retention of Armed Forces personnel. Participants must agree to have their military pay reduced by $100 per month for the first 12 months of active duty. Basic benefits are paid by VA and supplemental benefits by DoD.

The VSOs note that benefits under Chapter 34, Title 38, U.S.C.—*The "G.I. Bill" for Vietnam-era veterans*—ended for all training pursued after December 31, 1989. However, VA must make numerous adjustments and retroactive payments after that date. Also, individuals who were eligible for Chapter 34 benefits may be eligible for Chapter 30 benefits after December 31, 1989, provided they meet certain eligibility criteria.

- o *All Volunteer Force Educational Assistance (reservists):* Chapter 106, Title 10, U.S.C. This program provides education assistance to persons who enlist, reenlist or extend an enlistment in the Selected Reserve for not less than six years after June 30, 1985. The program's purpose is to encourage selected reserve membership. DoD and the Department of Transportation pay for the program, while VA administers it.

- o *Educational Assistance (dependents):* Chapter 35, Title 38, U.S.C. This program provides educational assistance benefits to the children and spouses of individuals who died from a service-connected disability or whose service-connected disability is rated permanent and total. Benefits are also provided to the dependents of servicepersons who are missing in action or are interned by a hostile government for more than 90 days.

- o *Special Assistance to Disabled Veterans (vocational rehabilitation):* Chapter 31, Title 38, U.S.C. This program provides benefits to disabled veterans enrolled in a program of vocational rehabilitation. The disabled veterans also receive payments for tuition, books, supplies, equipment and beneficiary travel. Provisions for extended evaluation and independent living services for disabled veterans are also included in the progam.

- o *Special Assistance to Disabled Veterans (housing grants):* Chapter 21, Title 38, U.S.C. This program provides grants of up to $38,000 to aid certain permanent and totally disabled veterans in acquiring a specially adapted housing unit with such fixtures or movable facilities as are made necessary by the nature of their service-connected disability.

- o *Special Assistance to Disabled Veterans (automobile grants and adaptive equipment):* Chapter 39, Title 38, U.S.C. This program provides for a one-time grant up to $5,500 for the purchase of an automobile or other conveyance for certain severely disabled veterans and servicepersons. It also provides for such adaptive equipment as is deemed necessary to ensure safe operation of the vehicle. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. Replacement or repair of adaptive equipment is also authorized.

The Omnibus Budget Reconciliation Act of 1990 contains a provision to limit vocational rehabilitation to veterans with service-connected disabilities rated 20 percent or more. Projected savings from this provision are $20 million in FY 1991 and $180 million in FYs 1991-1995.

In the FY 1991 Independent Budget, the VSOs emphasized the cost-effectiveness of vocational rehabilitation, as evidenced by the vastly increased income and other taxes paid by vocationally-rehabilitated veterans because of their greatly increased earnings. Vocational rehabilitation is not only good social policy, it is good economic policy. The lost federal tax revenue resulting from *not* providing vocational rehabilitation to service-connected disabled veterans clearly is not factored into this provision's projected "savings." The VSOs suspect that, over a five-year period, such savings will be non-existent and will actually result in a deficit situation in the out years.

Moreover, this provision affects service-connected veterans whose disabilities are rated 10 percent. These veterans, being less severely disabled than those with higher ratings, are the ones most likely to be quickly and successfully vocationally rehabilitated, with greatly increased earnings and a broadened federal tax base as the result. Targeting those veterans is, at best, misguided and certainly not cost-effective.

Also, we must state for the record that this provision is not a minor curtailment of an obscure entitlement; it is a major rescission of a very worthwhile program. Currently, the targets of this provision (that is, veterans with 10 percent service-connected disability ratings) account for 30 percent of the veterans reeeiving vocational rehabilitation services, by far the largest category of veterans by disability rating receiving those services. (Next are those rated at 20 percent or 30 percent, with each category accounting for 18 percent of the total.)

Some other observations: This provision rescinds an entitlement to service-connected disabled veterans that is not only available to but is mandatory for certain non-service-connected disabled veterans (disability pensions beneficiaries under age 45). It also directly counters longstanding federal policy that not only encourages but requires vocational rehabilitation for those individuals most likely to benefit from it. For example, a Social Security DIB recipient's cash benefits are suspended if he or she does not accept vocational rehabilitation services. The same Omnibus Budget Reconciliation Act of 1990 that slashes the Veterans' Vocational Rehabilitation Program requires the Social Security Administration to carry out vocational rehabilitation demonstration projects. These projects will access the advantages and disadvantages of permitting disabled beneficiaries (rather than SSA) to select a qualified rehabilitation agency, public or private, to provide them with services aimed at enabling them to become employed and self-supporting. (Title V, Subsection B, Section 5120.)

Finally, we doubt that the projected FY 1991 savings of $20 million will be realized. Because of inadequate staffing, applicants for vocational rehabilitation services must wait an average of 120 days before being interviewed. In addition, there is a substantial backlog of cases and, even with this provision, it is unlikely that it will be significantly reduced during FY 1991. Thus, this provision's benefits will not appear until FY 1992.

VETERANS INSURANCE AND INDEMNITIES

The Veterans Insurance and Indemnities (VI&I) appropriation is the funding mechanism for several government life insurance activities. Payments made from this fund include transfers to three government life insurance funds as well as direct payments to insurers and beneficiaries.

The largest category of obligations is the subsidy provided to the Service Disabled Veterans Insurance (SDVI) fund. That fund requires a subsidy, because it provides life insurance protection to veterans with service-connected disabilities at standard premium rates and is, therefore, not self-supporting.

Transfers are also made to the National Service Life Insurance (NSLI) and United States Government Life Insurance (USGLIF) funds for the payment of claims traceable to the extra hazards of military service. Extra hazard payments are primarily premiums being waived and disability payments being made where the disability was caused by the extra hazards of military service. By law, these extra hazard costs are borne by the government.

This fund also includes the obligations and collections of a small NSLI program under which policies were issued between 1946 and 1949 to veterans with service-connected disabilities. The VI&I appropriation also provides disability award payments to certain World War I veterans. These are total permanent disability awards that originated under the War Risk Insurance program, which was discontinued in 1926.

Also included under the VI&I appropriation is the Veterans Mortgage Life Insurance (VMLI) program. Public Law 100-322, enacted on May 20, 1988, transferred the VMLI program's administration from a commercial insurance company to VA, effective September 1, 1988. In addition, this legislation transferred the funding of VMLI expenses from the Compensation and Pensions appropriations to the Veterans Insurance and Indemnities appropriation. The program provides $40,000 mortgage protection life insurance to individuals who have received a grant for specially adapted housing. Policies are issued at standard premium rates to individuals who are considered health risks.

No provisions in the Omnibus Budget Reconciliation Act of 1990 affect this well-managed program. The FY 1991 appropriation for VI&I amounts to only $15.4 million.

The VSOs do, however, have two legislative recommendations.

The VSOs support legislative proposals relating to the VMLI Program and SDVI fund (commonly called RH Life Insurance). The proposals would:

Increase VMLI Face-Value Coverage from $40,000 to $90,000

The maximum coverage has not been increased since 1976. Since then, housing costs have risen 188 percent. According to VA, more than 60 percent of those who were issued VMLI coverage during the past ten years had mortgages of more than $40,000. Thus, the current maximum coverage amount, does not cover many catastrophically-disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

The proposed increase in the maximum VMLI amount is clearly necessary. The CBO cost estimate is $2 million in FY 1991 and $10 million in FYs 1991-1995.

Increase the Maximum Amount of Available SDVI Life Insurance from $10,000 to $20,000

The maximum amount of SDVI life insurance available to eligible veterans has not increased since 1951, when the legislation creating the program was enacted.

The CBO cost estimate is $1 million in FY 1991 and $5 million in FYs 1991-1995.

LOAN GUARANTY REVOLVING FUND AND GUARANTY AND INDEMNITY FUND

Congress created the Home Loan Guaranty Program in 1944 to assist returning veterans, who were unable to maintain a suitable credit rating or achieve the necessary savings, to afford a downpayment on a home. Originally, the legislation called for a sunset provision of five years; however, because of the program's popularity and success, Congress permanently codified it in Title 38 in 1970. The Loan Guaranty Revolving Fund financed the program's operation.

For the past decade, however, the Loan Guaranty Revolving Fund (LGRF) has required substantial appropriations to maintain its solvency. The deficits in LGRF were caused by high foreclosure rates; however, as described in prior Independent Budgets, misguided OMB policies, ineffective management practices and an inadequate number of employees to administer the program also contributed significantly to LGRF deficits.

Congress addressed the problems in The Veterans Benefits Amendments of 1989. This comprehensive legislation included a provision that established the Guaranty and Indemnity Fund (GIF). GIF finances the operation of the Loan Guaranty Program for loans made on or after January 1, 1990. A major feature of the legislation is to indemnify veterans who default on their home loans against liability to VA.

In the event of an insoluble default, VA, through its contract of guarantee, stands ready to make good any loss the loanholder sustains up to the guarantee amount. To offset expenses, the basic loan guarantee fee was raised from 1 percent to 1.25 percent (compensably rated service-connected disabled veterans and spouses of deceased service-connected veterans are exempt from the fee). On loans with 5- or 10-percent downpayments, the loan fee was reduced to 0.75 percent and 0.50 percent, respectively. For loans made during the period beginning November 1, 1990, and ending on September 30, 1991, the Omnibus Budget Reconciliation Act of 1990 increases each of these fees by 0.625 percent. Thus, the basic fee is 1.875 percent and the fees for 5-percent and 10-percent downpayment loans are 1.375 percent and 1.175 percent respectively.

The government contributes 0.75 percent for each guaranteed loan (spread over three years) and, for loans with a 10-percent downpayment, 0.50 percent (spread over two years) to GIF.

Under current legislation, the guaranty amounts are as follows:

- 50 percent for loans of $45,000 or less;
- The lesser of $36,000 or 40 percent (minimum of $22,500) for loans greater than $45,000 but not more than $144,000;
- The lesser of $46,000 or 25 percent for loans greater than $144,000 to purchase or construct a home.

The past three Independent Budgets described the VSOs' growing frustration with the enormous deficits in the Loan Guaranty Revolving Fund (LGRF) and the budgetary and management policies and practices that caused them. To update the damage: With FY 1991 appropriations of $670.2 million, the LGRF has run up a total deficit of $4.42 billion dollars since 1984.

For the record, we must make an obvious point: *Not one dime of this $4.42 billion deficit has gone into the pocket of a veteran* . Hundreds of thousands of veterans, however, have lost their homes and credit needlessly, because of disastrous budgetary and administrative policies.

In the FY 1991 Independent Budget, the VSOs observed:

> These deficits were not caused simply by poor economic conditions or "bad luck." This truth is obvious, based solely on the historical record. The nation, unfortunately, has experienced relatively frequent recessions and, over the years, local and regional economies such as the Southwest's have been devastated.

The Home Loan Guaranty Program was started in 1944. For years the program was almost completely self-sustaining without any "user fee." The reason for this was that VA had *a sufficient number of employees to administer and regulate the program in the interest of its intended beneficiary, the veteran.* The natural adjunct of this was an extremely cost-effective program which benefited not only veterans but the whole nation, spurring new home construction, creating jobs and raising virtually every U.S. community's tax base.

During the past decade, short-sighted budgetary policies have reduced this excellent program to shambles and victimized hundreds of thousands of veterans. Yet, the cruel irony is that the victims are expected to pay the price for these policies in the form of ever-increasing "user fees." User fees go directly against the program's original intent and purpose, by charging a substantial fee for an entitlement that veterans earned by service in the Armed Forces. They also effectively deny that entitlement to many of those whom it was specifically designed to help—veterans who, because of their military service, were unable to save enough for a downpayment on a home (to say nothing of the savings necessary to pay a substantial user fee).

Now, however, less than a year after the enactment of comprehensive legislation, which established the Guaranty and Indemnity Fund and was designed to restore the program's long-term solvency, the Omnibus Budget Reconciliation Act raises the basic user fee by 50 percent and the fees for 5- and 10-percent downpayment loans by even greater percentages.

The Veterans Benefits Amendments of 1989, which established GIF, were a product of the normal legislative process—Congress held hearings, interested groups had the opportunity to express their views, parties involved reached compromises, and Congress produced the legislation. Congress increased the user fee from 1 to 1.25 percent, but earmarked the increase to indemnify veterans who default against liability to VA. In contrast, the Omnibus Budget Reconciliation Act summarily increased the basic user fee by 50 percent, disregarding the delicate balance between program intent/purpose and fund solvency, which was the framework and driving force behind the Veterans Benefits Amendments of 1989.

This knee-jerk increase in the user fee, which the greatly decreased number of veterans who still qualify for a VA loan will bear, was not the only proposal for reducing Home Loan Guaranty costs. For several years, the VSOs have preached and demonstrated a simple truth: Providing VA with enough employees to properly administer the program and serve veterans' needs will produce enormous savings.

In the FY 1991 Independent Budget, we illustrated the correlation between additional FTEEs and program savings by reference to VA's savings estimates when it requested additional Loan Guaranty FTEEs in an FY 1990 budget request amendment. VA requested 244 FTEEs, which it estimated would generate $81.8 million in program savings, or $335,246 per FTEE. The Houston Pilot Servicing Project showed that even greater savings are achieved when good service is provided to veterans.

VA's report to OMB on the first 12 months of the project (August 1988-July 1989) demonstrates the impact of good management, innovative policies, and additional FTEEs on loan servicing. During the preceding 12 months, the average number of Loan Service Representatives (LSRs) was ten; during the project period, the average number was 19.55. More precisely, the total unit hours worked during the project period were 45,276. Using an adjusted work year of 1860 hours, during the report period there were 24 FTEEs (45,276 divided by 1860). The total LSR work hours for the preceding 12-month period are not stated in the report; however, at most, 14 more work years were available during the project period.

The report's conclusion stated:

> The Project was successful from a cost/benefit standpoint. Counting only "successful intervention" cases, documented savings due to reduced foreclosures exceed $11,000,000. We believe it is likely that at least an equal number of foreclosures were avoided through VA personal supplemental servicing assistance in cases in which it was not necessary for VA to intervene directly with the loan holder. The savings compare quite favorably with the estimated costs involved in the Project of $310,000 (approximately $290,000 for personnel and $20,000 for equipment).
>
> In connection with improved service to veteran borrowers in need of advice and assistance, our Houston office notes that they have received numerous expressions of gratitude from veterans for the help provided during the Project. We therefore believe the Project has done a great deal to improve the Department's image and reputation. Overall, we consider the Project to be highly successful.

The actual documented savings resulted from 559 successful interventions (direct contact with the lender regarding delinquent loans where foreclosure is avoided) and amounted to $11,224,463 in VA-avoided claim and acquisition costs. This was achieved because with ten additional employees, personal contacts increased by 105 percent. Project costs totaled $310,000; thus, net documented savings were $10,915,463. Savings per additional employee were $1,091,546, and, for each additional work year, savings were $779,676.

VA estimates that at least as many foreclosures were avoided through personal supplementing servicing assistance which made direct intervention with the lender unnecessary. This, of course, would double the savings, and mean that more than 1,100 veterans and their families, who otherwise would not have, kept their homes.

The Omnibus Budget Reconciliation Act's increased user fees are estimated to produce $79 million in revenues for FY 1991, but, at the same time, they will decrease the program's access to those veterans who most need it. Moreover, they will have *no* positive impact on the real problem, which is reducing LGRF deficits. Providing good program service is the only way to do this, and the Houston Project has demonstrated just how cost-effective this can be. Ten additional employees provided direct program savings of more than $11 million, and it is more than likely that they were responsible for avoiding another $11 million in program costs.

By way of comparison, the Omnibus Budget Reconciliation Act establishes a Medical-Care Cost Recovery Fund by a transfer of $25 million from the LGRF to support 800 additional FTEEs (and other administrative costs) for third-party recoveries from insurers and collecting co-payments from veterans for medication and health care services. (Ironically, this is the additional amount the VSOs recommended in the FY 1991 Independent Budget for all Veterans Benefits Administration activities to restore adequate services to veterans.)

> *We strongly oppose all entitlement cuts because they are unfair and unnecessary.*

The VSOs acquiesce in the third party recovery aspect of the legislation. According to the Conference Agreement Report, projected savings are $113 million for FY 1991 and $826 million for FYs 1991-1995. This means that the savings per each of 800 employees would be $141,250 for FY 1991 and $1,032,500 for FYs 1991-1995, or, over five years, an average yearly savings of $206,500. Cost-effective to be sure, but contrast this with the savings per employee engaged in improved loan servicing activities, which are at least four times higher and possibly eight.

The legislation provides that LGRF will be reimbursed; however, the administrative cost of third party recoveries will then be funded by the Medical-Care Cost Recovery Fund. The VSOs believe that the same principle should apply to the Home Loan Guaranty Program's administrative costs. It is now indisputable that, had there been sufficient FTEEs to provide good loan service to veterans, at a minimum LGRF deficits would have been much less. It is not too late to do the right thing, and the innovative funding mechanisms the Omnibus Budget Reconciliation Act introduces establish a clear precedent for doing so.

Another proposal relating to this program, which would have produced greater savings than the enacted user fee increases, was part of the Budget Summit Agreement. The proposal was to include resale losses in net value for purposes of the formula used to determine whether VA would acquire a foreclosed property (the no-bid formula).

The fear has been expressed that this provision would affect some lenders' willingness to make VA-guaranteed loans and therefore limit the number of veterans able to use their VA entitlement to buy homes. The VSOs believe that this is something to strive for rather than fear. VA-guaranteed loans made by responsible lenders to credit-worthy veterans are not the problem; indeed, this is exactly what the program is intended to do. The problem is the practice that encourages lenders to make marginal or bad loans, with virtually no risk to the lenders in the event of default/foreclosure. As we will discuss below, the savings to the program from this provision would be substantial and, at the same time, it would act as a powerful deterrent to lenders making bad loans, a highly-desirable goal.

Congress, however, rejected this proposal in favor of increasing the basic loan fee by 50 percent, a provision which undoubtedly limits veterans' ability to use their VA entitlement.

Active duty military personnel are also entitled to use the Home Loan Guaranty Program. These individuals are the least able to ride out soft or declining real estate markets because they frequently must sell their homes a short time after purchasing them, either because of transfer or separation from active duty. Under these circumstances, foreclosures are almost inevitable in a declining real estate market. Clearly, VA's budget should not have to absorb the foreclosure costs on loans made to active-duty military personnel; those costs should be paid from the Department of Defense (DoD) budget.

The VSOs are convinced that, with improved underwriting standards and loan servicing and effective oversight and regulation of lenders, the Home Loan Guaranty Program would soon be self-sufficient *without any user fees*. Indeed, it was the understanding of the VSOs in supporting the establishment of GIF, that the gradual reduction and ultimate elimination of the user fee would occur as the program returned to solvency.

BENEFITS PROGRAM SUMMARY

The VSOs accept the deficit reduction provision for third-party medical-care cost recoveries (but not veteran co-payments for medication and health care). We support the provisions designed to ensure that only those veterans and their dependents who are entitled to benefits receive them in the correct amount. We strongly oppose all entitlement cuts because they are unfair and unnecessary to achieve thedeficit reduction targets the Omnibus Budget Reconciliation Act of 1990 mandates.

In the following section, the VSOs will address Benefits Programs within the context of the Omnibus Budget Reconciliation Act of 1990, with specific reference to Title XIII of the Act (The Budget Enforcement Act of 1990). We will also offer an alternative deficit reduction plan (as it affects the VA budget) that is both fair and does not violate the programs' intent and purpose.

THE VSOS' PLAN

The VA's budget for the programs it administers must be viewed within the context of the Omnibus Budget Reconciliation Act of 1990 (OBRA). OBRA is *the* enacted legislative plan for deficit control over the five-year period from FY 1991 to FY 1995, and all deficit reduction efforts, including VA's, should comply with its terms and underlying presumptions.

The Budget Enforcement Act of 1990 (Title XIII of OBRA) sets five-year targets for deficit control that include caps or limits on categories of discretionary spending. Veterans Benefits Programs are within the domestic spending category (the others are defense and international) and its attendant spending limits and enforcement procedures. Under OBRA, however, domestic spending is allowed to rise with inflation from current spending levels. (Also, it is interesting to note that, for FYs 1991-1993, more than $20 billion in additional budget authority for domestic spending was part of the political agreement that produced OBRA.)

These spending limits and enforcement procedures are designed to maintain the revenue increases and spending cuts enacted to reduce the deficit by $40 billion in FY 1991 and $500 billion in FYs 1991-1995, which are the starting points of OBRA.

To achieve these deficit reduction targets, authorizing committees of Congress were instructed by the Budget Committee to report changes in laws within their respective jurisdictions that would achieve specified savings. For the House and Senate Veterans Affairs Committees, these amounts were $620 million for FY 1991 and $3.35 billion for FYs 1991-1995. Exactly how these savings were to be achieved was left to the authorizing committees. If the savings specified in the reconciliation instructions from the Budget Committee were achieved, it would not matter how they were achieved.

The savings were incorporated in the Conference Report on the Concurrent Resolution On The Budget - Fiscal Year 1991 (Report 101-802, October 4, 1990), which established the budget for FY 1991 and set forth the appropriate budgetary authorities for FYs 1992-1995. For VA, the established budget authority for FY 1991 and the appropriate budgetary authorities set forth for FYs 1992-1995 are:

FY	Budget Authority (in billions)
1991	31.3
1992	32.4
1993	33.4
1994	34.4
1995	35.4

In addition, however, Title XIV of OBRA includes the statement:

> The House Democratic leadership believes that every effort must be made to advance legislatively in budget resolutions, authorizing bills and appropriation bills funding levels which will achieve the goals set forth for the following [eight budget] functions.

One of the specified functions is Veterans Benefits and Services. The Democratic leadership states:

> Increases over current services provided for under this function should reach, at least, $500 million in Budget Authority and $500 million in Outlays by FY 1993 and, to the degree possible, be targeted for expanding Education, Training and Rehabilitation and for increases in Veterans Housing, Hospital and Medical Benefits.

This indicates that VA can reasonably expect to receive a significant portion of the more than $20 billion in *additional* budget authority mentioned above (at least $500 million by FY 1993). *The VSOs wish to acknowledge the efforts of the Congressional Black Caucus in obtaining the commitment of the House Democratic leadership that at least $500 million be added to VA's budget by FY 1993.*

The VSOs have already offered our assessment on the manner in which the Veterans Affairs Committees (VACs) chose to implement the reconciliation instructions. Given the reality of these instructions, however, it is incumbent upon us to present our independent views on how the VACs could have complied with the Budget Committee's reconciliation instructions in a manner more acceptable to veterans and their dependents.

There is another challenge. Now that deficit reduction legislation has been enacted, any changes in law that would reduce revenues or increase entitlement program beneficiaries must comply with the pay-as-you-go provisions of Title XIII of OBRA; that is, there must be a corresponding revenue increase to conform to the legislated deficit reduction targets/spending limits.

We believe we can meet this challenge, but before doing so, we would like to make a general observation regarding OBRA. It remains to be seen how effective OBRA will be in practice, but its initial results leave much to be desired. The first and most important installment of it was not played on a level field.

Total VA appropriations for FY 1990 were $29.2 billion. The reconciliation instructions for $3.35 billion savings over five years amount to 11.5 percent of FY 1990 appropriations, and the enacted savings of $3.7 billion amount to 12.7 percent FY 1990 appropriations. We don't understand how and why Congress decided that Veterans Programs were to take such a major "hit," especially considering the already greatly eroded level of health care and benefit delivery services.

With that said, the VSOs must deal with the current reality and present our recommendations for meeting the deficit reduction targets of $620 million for FY 1991 and $3.35 billion for FYs 1991-1995, consistent with OBRA's provisions.

THE VSOS' RECOMMENDATIONS FOR DEFICIT REDUCTION

The elements of the VSOs' deficit reduction plan either build on some enacted OBRA provisions or are based on our interpretation of OBRA's Title XVIII (The Budget Enforcement Act of 1990) and other legislative precedents. Although some elements of the plan are not incorporated specifically within enacted legislation (for example, crediting savings from the attrition of the compensation and pension rolls) we believe there is ample supporting authority for our position.

First, OBRA's goal is to reduce the deficit by maintaining spending at set limits. This means that VA's budget authority for FYs 1991-1995 has been set by law and appropriations in those set amounts should be forthcoming. The premise of the Independent Budget's deficit reduction plan is that internally-generated savings exceeding the deficit reduction targets, incorporated both within OBRA and the budget authority allocations for FYs 1991-1995, can and should be used internally by VA. These excess savings are not additional appropriations and their use therefore will have no effect on the FYs 1991-1995 budget authority allocations set in the Concurrent Budget Resolution.

Authority and Precedent for the Independent Budget's Position

- The OBRA Conference Agreement Scorekeeping Rules. (Conference Report to accompany H.R. 5835, Report 101-964, p. 1173).

Rule 3 provides, "Entitlement and other mandatory programs (including offsetting receipts) will be scored at current law levels, unless Congressional action modifies the authorizing legislation." The Independent Budget uses current law levels as the baseline for our deficit reduction plan. Rule 4 permit transfers of budget authority from the mandatory (Benefits Program) account to a discretionary (GOE) account, which has been done in several provisions of OBRA and is part of the Independent Budget's recommended approach. Rule 5 provides that permissive transfer outlays "will be estimated based on the best information available, primarily historical experience..." This is *exactly* what the Independent Budget does in estimating savings from the Compensation and Pension accounts.

- Permissive Transfers as Proposed in the Independent Budget Occurred Prior to OBRA.

A good example of this is described in VA's FY 1991 budget submission. A projected $183.8 million surplus in 1990 for the Pension account was used to help fund the compensation COLA. Further supporting our recommendation that internally-generated savings exceeding deficit reduction targets be retained by VA for improving health care and benefits service to veterans is the fact that Congressional authorizing committees can and do earmark where projected savings should be spent. For example, in its report to the Budget Committee on VA's FY 1991 budget request, the House Veterans Affairs Committee commented on VA's proposal for an IRS match by stating,

> "The Committee wishes to emphasize that this proposal will not be reported unless the resulting savings are made available for discretionary programs in the veterans function." (House Committee Print No. 6, dated February 28, 1990)

We start then with the presumption that achieving the deficit reduction targets from current spending levels is the goal and that, although how this occurs does not matter for budget reconciliation purposes, entitlements should be cut only as a last resort. We also assume that Veterans Benefits Programs appropriations, because they are included in the OBRA domestic spending category, should, like other programs, be allowed to rise with the level of inflation, albeit after meeting deficit reduction targets. Certainly, veterans are entitled to at least this degree of equity.

Under these presumptions, the VSOs are convinced that the normal compensation and pension rolls attrition, efficient third-party medical care cost recoveries, income matching for legitimate program purposes, and administrative and program reforms in the Home Loan Guaranty Program would more than meet deficit reduction targets. The following discussion explains how.

PENSIONS

The Pensions program has not contributed to the deficit problem. We say this because, as the number of aged persons in the general population grows, the number of aged wartime veterans eligible and potentially eligible for a pension continues to shrink. For example, in FY 1984 the number of non-service-connected disability veteran pension recipients was 749,838, and the number of survivor's pension recipients was 846,087, for a total of 1,595,925. In FY 1989, the corresponding figures were 592,386 (-157,452); 573,894 (-272,193); and 1,166,280 (-429,645), respectively.

Moreover, the number of pension recipients and the amount of outlays are shrinking even faster than VA anticipated. As explained in the FY 1991 VA budget submission, the original VA budget estimate for FY 1990 was revised downward based on actual 1989 experience. The number of beneficiaries was 10,318 fewer than the original estimate (non-service-connected disability pension accounted for 9,779 of the total decrease) and the average payment also was lower than originally estimated. *The result was a $183.8 million surplus in the Pensions program for FY 1990* that was transferred to the Compensation program to help fund the COLA.

The FY 1991 VA budget estimate of veterans on the pension rolls was 550,116, a decrease of 17,715 from the revised FY 1990 estimate and 42,270 from the FY 1989 actual. For veterans and survivors, the decrease in total beneficiaries between the FY 1991 estimate and the FY 1989 actual was 106,447!

The veteran population's demographics make it inevitable that the pension rolls' attrition will not only continue but accelerate. Sixty-six percent of non-service-connected disability pension beneficiaries are 65 years of age or older. Currently, 76.5 percent of all pension beneficiaries are World War II veterans and 16.4 percent are veterans of the Korean Conflict. Between FY 1984 and FY 1989, the number of World War II veterans receiving pensions decreased by 110,691, and the number of Korean Conflict veterans receiving pensions increased by 8,905. Thus, the decreased number of World War II veterans receiving pensions exceeded the additional number of Korean Conflict veterans receiving pensions by a ratio of more than 12 to one.

The Korean Conflict wartime period ended January 31, 1955, and the number of these wartime veterans who become eligible for pensions based on being age 65 should peak within the next five years. The pensions rolls, however, will continue to decrease substantially because of the far greater number of World War II (and Korean Conflict) beneficiaries' deaths. The pension rolls will then decline even more precipitously, because there is more than a nine-year gap between the end of the Korean Conflict (January 31, 1955) and the beginning of the next wartime period (the Vietnam wartime period began on August 5, 1964).

Within the context of OBRA, these facts yield enormous savings that should be credited toward deficit reduction targets. OBRA's economic assumptions include increases in the consumer price index (inflation rate). For FY 1991, the inflation rate was 5.4 percent. OBRA assumes a rate of inflation for subsequent years as follows: FY 1992 - 4.2 percent; FY 1993 - 4.3 percent; FY 1994 - 4.3 percent; and FY 1995 - 4.3 percent. As stated above, OBRA allows spending for domestic programs to rise with the rate of inflation. Using FY 1990 as the base year yields the following results.

FY 1990 Pensions appropriations were $3.918 billion. Applying the FY 1991 inflation rate of 5.4 percent to FY 1990 appropriations results in allowed 1991 outlays of $4.130 billion.

Enacted FY 1991 Pensions appropriations (after an upward revision of $230.4 million from the original estimate) are $3.992 billion. Because spending rose less than the inflation rate, pension spending would be below the OBRA target by $138 million (4.130 - 3.992). These are real savings under OBRA presumptions, and should be credited as such for deficit reduction purposes.

Continuing with the OBRA inflation assumptions, the potential pension savings are considerable. Pensions spending would rise as follows:

FY	Inflation	Spending
1992	4.2	4.303 billion
1993	4.3	4.488 billion
1994	4.3	4.680 billion
1995	4.3	4.881 billion
Total		18.352 billion

If, for example, pension spending remained at the FY 1991 appropriated level of $3.992 billion during FYs 1992-1995, total spending during that period would be $15.968 billion. The theoretical savings for FYs 1992-1995 would be $2.384 billion (18.352-15.968).

The VSOs do not intend to claim savings from an increasingly-inflated base that will not occur. The above example is provided to contrast the level of pensions spending that

OBRA would allow with what will actually occur. This, we think, further illustrates the inequity of enacted entitlement cuts in Veterans Benefits Programs. We will, however, claim savings that will accrue based on realistic year-by-year estimates of actual spending for FYs 1991-1995, which are less than the OBRA-assumed inflation rates.

Our spending estimates for FYs 1991-1995 use the best evidence available—actual experience during the preceding five years (FY 1986-1990) and the veteran population's demographics.

The first observation to be made about spending during FYs 1986-1990 is that veterans' programs had nothing to do with creating the budget crisis! Total VA appropriations in FY 1986 were $26.2 billion and $29.2 billion in FY 1990. Thus, during the five-year period, appropriations rose by $3 billion or 11.4 percent, an annual rate of increase of 2.3 percent. If all federal spending had risen at an annual rate of only 2.3 percent, there would be no budget crisis.

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Pensions spending did not rise at all. For FYs 1986-1990 Pensions spending was as follows: (FYs 1986-1989 totals are actual obligations; FY 1990 is enacted appropriations).

FY	$ (thousands)
1986	3,850,179
1987	3,792,945
1988	3,826,974
1989	3,845,610
1990	3,918,100

The average annual spending was $3,846,762,000. Using FY 1985 as a base year for comparison, FYs 1986-1990 spending was remarkably static; FY 1985 actual obligations were $3,846,873,000. Given the demographics discussed above, during the next five years pension spending will, at most, remain flat, even with full COLAs. Therefore, in each year pension spending will be below OBRA limits at least by the rate of inflation and, at a minimum, that amount should be credited as savings.

As stated above, for FY 1991 that amount is $138 million, based on the inflation-adjusted difference between FY 1990 and FY 1991 appropriations. We think the revised estimate for FY 1991 ($3.992 billion) is high. If actual obligations *for pension payments* (and not administrative costs drawn from this account) prove this to be true, the amount by which actual obligations are less than the estimate also should be credited as savings.

For FYs 1992-1995, the amount by which actual spending is less than the inflation rate also would be credited as savings. For now, we have only the OBRA inflation rate assumptions, 4.2 percent for FY 1992 and 4.3 percent for FYs 1993-1995. Based solely on actual data for FYs 1986-1990, it is a certainty that pension outlays will not increase. Applying OBRA-assumed inflation rates to FY 1991 appropriations of $3.992 billion as a constant baseline for FYs 1992-1995 yields the following savings, which should be credited toward deficit reduction: FY 1992 - $168 million; FYs 1993-1995 - $172 million each year, for a four-year total of $684 million. Added to FY 1991 savings of $138 million, total creditable savings are $822 million.

In addition, the VSOs believe it is inevitable that Pensions spending during 1991-1995 will actually decline. Assuming a very modest 1 percent decline per year results in savings of approximately $40 million a year. We believe that this amount should also be credited for a total Pensions savings of $1.022 billion, distributed as follows (dollars in millions):

	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	Total
Spending at less than inflation	138	168	172	172	172	822
Spending decrease	40	40	40	40	40	200
Total	178	208	212	212	212	1,022

THE IRS INCOME MATCH

This provision's sunset date is September 30, 1992, but the Congressional Budget Office (CBO) has projected savings for FY 1991-1995 of $743 million. FY 1991 savings, however, are projected to be only $28 million.

VA anticipated this legislation for some time. VA's FY 1991 budget submission estimated FY 1991 savings from this provision, if enacted, at $61 million. The VSOs believe that FY 1991 savings may be considerably higher. The legislation calls only for a two-year period of access to IRS data; therefore, the income match with current needs-based pension beneficiaries should be accomplished within that period. A GAO study (GAO/HRD-88-24) published in March 1988 reported the results of matching 1984 income, as disclosed by IRS data, with the income pension beneficiaries reported to VA. GAO estimated potential overpayments of $182.5 million to nearly 149,000 beneficiaries and terms this estimate "conservative." The potential overpayments of $182.5 million represented approximately 4.7 percent of FY 1984 Pensions outlays ($3.9 billion).

Since 1984, Pensions outlays have remained almost constant. Therefore, based on the GAO estimate, the projected five-year savings of $743 million could be achieved by accessing IRS data for the last four years, during the two-year period this provision is in effect. Future savings would also accrue from nonpayment or reduction of COLAs to those found ineligible or entitled to a lesser amount, fewer individuals applying for benefits because of the deterrent effect of the income match, and fewer of the applicants being found eligible because of the access to IRS data. In addition, these provisions undoubtedly will reduce the average monthly payment to those found eligible.

Thus, the projected FY 1991-1995 savings of $743 million are easily justified, although the VSOs believe that FY 1991 savings will amount to at least $90 million (less than half of one-year overpayments).

It is important to emphasize that these savings will accrue as a result of income verification over a two-year period. The VSOs have no objection to income verification *for legitimate program purposes* and see no reason why this provision, as it relates to means-tested compensation and pension programs, should not be made permanent. If it is, more in savings will be achieved for FYs 1991-1995 than the projected $743 million.

By FY 1993, the overpayment potential will have been reduced substantially, and a permanent provision for an IRS income match will reduce it further. For 1993, we estimate that access to IRS data should produce savings of 2 percent of our estimated outlays, or approximately $80 million. We project savings of $60 million for FY 1994 and $50 million for FY 1995, for a total of $190 million more than the projected $743 million.

In summary, a permanent provision for an IRS match should produce savings of $90 million for FY 1991 and $933 million for FYs 1991-1995.

COMPENSATION

As with pensions, actual experience during the five years prior to FY 1991 is the best evidence concerning the dynamics and future direction of the Compensation program.

In FY 1986, actual compensation payment obligations were $10.4 billion, and in FY 1990 appropriations were $11.6 billion. This is an 11.5 percent increase over a five-year period, or an average increase of 2.3 percent per year. The caseload in FY 1986 was 2,566,327 (2,231,853 veterans and 334,474 survivors), and in FY 1990, the actual caseload was 2,508,761 (2,187,822 veterans and 320,939 survivors). From FY 1986 to FY 1990, the number of veterans and survivors receiving compensation decreased by 57,566. In FY 1986, the average yearly compensation payment was $3,756 and in FY 1990 it was $4,246, an increase of 13 percent, or 2.6 percent per year over the five-year period, which is well below the period's rate of COLA increase.

The reason for this is explained in the VA's FY 1991 budget submission:

> The average benefit payment for veterans will increase in 1990 as a result of the 4.7 percent cost of living adjustment and will then decrease in 1991. During recent years the average degree of disability and the average number of dependents per case has been declining. As veterans from older periods of service leave the rolls, they are being replaced by younger veterans who have a lower degree of disability.

The cumulative effect of this is illustrated by the fact that enacted FY 1991 appropriations, based on an upwardly-revised VA estimate from the original budget submission, are $152 million *less* than the FY 1990 obligations. There is every reason to believe that this trend will continue and that, like pensions, compensation spending will be flat over the next five years.

No assumptions need be made for FY 1991 because appropriations have been made and can be compared with FY 199 actuals. In estimating spending for FYs 1992-1995, we will be extremely conservative and assume that compensation spending will increase at the same 2.3 annual rate it did during FYs 1986-1990.

FY 1990 actual obligations were $11.662 billion. Applying the actual 5.4 percent inflation rate to that amount results in $12.292 billion, which under OBRA would be allowed spending. FY 1991 appropriations are $11.509 billion. Thus, under OBRA, $783 million (12.292 billion - 11.509 billion) would be credited toward deficit reduction.

The FY 1991 appropriations did not include funds for the 5.4 percent COLA. This would require an additional $303 million. At a minimum, then, $480 million ($783 million minus $303 million) would be credited toward deficit reduction for FY 1991.

For FY 1992, compensation spending will be 1.9 percent less than the OBRA-assumed rate of inflation (4.2 percent - 2.3 percent), and for FYs 1993-1995, it will be 2 percent less. Applying these percentages to FY 1991 appropriations as the constant base to determine the amount compensation spending will be less than the inflation rate, and therefore credited toward deficit reduction, results in the following savings: $219 million for FY 1992 and $230 million for FYs 1993-1995, total savings for FYs 1992-1995 of $909 million. Total FYs 1991-1995 savings will be $1.519 billion (909 million + 610 million) if the COLA for FY 1991 is not fully funded or $1.692 billion (909 million + 783 million) if the FY 1991 COLA is fully funded.

To this must be added the savings that will accrue as a result of the enacted FY 1991 COLA delay. Delaying payment of one month's COLA for a year is projected to save $49 million in FY 1991. Obviously, additional savings will be realized due to the delay in the enactment of the FY 1991 compensation COLA. Optimistically, it will be April 1991 before veterans will receive an enacted COLA. Based on this assumption, an additional four months COLA will have been delayed. The VSOs therefore believe that any savings associated with the additional compensation COLA delay should be credited.

Total compensation savings that VA can apply against deficit reduction are (dollars in millions):

	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	Total
Spending at less than inflation	480	219	230	230	230	1,389
COLA Delay (1 month)	49+					49+
(plus savings from additional months delay)						
Total	529+	219	230	230	230	1,438+

MEDICAL CARE COST RECOVERY

According to the CBO estimate accompanying the Conference Agreement Report on this legislation, this provision's projected savings are $113 million for FY 1991 and $826 million for FYs 1991-1995. The VSOs' deficit reduction plan includes these savings. The provision sunsets September 30, 1993.

SOCIAL SECURITY NUMBER DISCLOSURE - DEATH VERIFICATION

According to CBO, this provision would result in savings of $4 million for FY 1991 and $47 million for FYs 1991-1995. The VSOs support this provision and credit these savings toward our deficit reduction recommendations.

HOME LOAN GUARANTY

The solution for significantly reducing, if not eliminating, deficits in this program has been obvious for years: Provide enough employees to properly administer and regulate the program in the interests of veterans. The Houston Pilot Project report quantifies the savings that are generated by the work of additional employees.

The cured defaults attributed to ten additional employees resulted in direct savings of $1.1 million per employee, and VA estimated that another $1.1 million per employee was saved by preventing defaults.

In the face of this evidence and the fact that the FY 1991 appropriations of $670.2 million were $158 million more than the original budget estimate, "due to a higher than anticipated foreclosure rate," it is difficult to understand why additional employees have not been authorized for immensely cost-effective service improvements. *As a matter of public policy and pure economics, who can oppose default and foreclosure prevention?*

The VSOs therefore recommend authorization of 150 additional employees for Loan Guaranty over the number currently authorized by FY 1991 appropriations. Based on the Houston Pilot experience, $1.1 million in direct savings per employee per year can be anticipated. We also believe that at least $400,000 of the estimated $1.1 million in indirect annual savings per employee should also be credited toward deficit reduction for a total of $1.5 million savings per employee per year.

We are already into FY 1991 and the full annual savings from this recommendation would not be realized. Our savings estimates from this recommendation therefore are: FY 1991 - $100 million; FYs 1992-1993 - $225 million each year; FYs 1991-1995: $1 billion.

This will make substantial inroads into the $2.5 billion foreclosure losses that GAO recently predicted will occur over the next several years.

The deficit reduction savings from this program do not end here. The Budget Summit Agreement included a proposal to include resale losses in net-value to determine whether VA will acquire a foreclosed property. The VSOs support this proposal for several reasons. It produces much greater savings then increasing the user fees. It does not have a negative impact on veterans who must default on their loans. It will substantially reduce VA foreclosure-associated costs. It will place an element of risk where it belongs—with the lenders. It will serve as an effective deterrent to making bad loans because of the risk involved in continuing this practice, and it will automatically improve lender underwriting standards. The proposal not only would reduce LGRF deficits, but would go a long way toward ensuring the solvency of GIF.

CBO advises that VA's savings estimate from this provision was $80 million for FY 1991 and $445 million for FYs 1991-1995.

The VSO's Loan Guaranty deficit reduction recommendations would yield the following savings (dollars in millions):

	FY 1991	FY 1992-1995	Total
Additional FTEEs (millions)	100	900	1,000
Include resale losses	80	365	445
Total	180	1,265	1,445

These savings easily justify repeal of OBRA's user fee increases. Moreover, as the LGRF deficit decreases, so should the user fee.

In addition, although it would not reduce the total federal deficit, DoD appropriations should reimburse VA for the cost associated with active duty personnel foreclosures. We see *no* justification for charging these costs to VA's budget.

In accordance with the Federal Credit Reform Act of 1990 (included in OBRA's Title XIII), Loan Guaranty's administration costs are funded by reimbursements from the LGRF and GIF. The VSOs endorse this reform.

Finally, the above recommendations are directed toward identifying quantifiable savings, primarily in the loan servicing area. VA management has implemented a number of initiatives that undoubtedly are cost-effective—for example, the loan production system and the establishment of a lender auditing team. In addition, there have been improvements in the property management area. Given sufficient resources, VA can restore this program to its past stability and effectiveness.

The VSO's deficit reduction plan is summarized in Table 17.

PROPOSALS TO IMPLEMENT THE VSO DEFICIT REDUCTION PLAN

The savings identified above can be achieved with *no* entitlement cuts or modifications, no increases in user fees, and no co-payments. The savings are all internally generated within the framework of Benefits Programs' intent and purpose and VA's administrative structure for implementing and delivering them. Our savings estimates are fully rationalized and supported by empirical demographic data and projections, the VA report on actual and estimated savings realized by improved loan servicing, and CBO estimates used by Congress. Obviously, the savings are more than sufficient to meet the deficit reduction targets OBRA has set for Veterans Programs and the methods for achieving savings have the virtue of being fair.

TABLE 17
The VSO Deficit Reduction Plan
(dollars in millions)

	Savings FY 1991	FYs 1991-1995
PENSIONS		
a. Outlays less than inflation	138	822
b. Decrease in outlays from FY 1990 base	40	200
IRS Income Match (no sunset date)	90	933
COMPENSATION		
a. Outlays less than inflation	480	1,389
b. COLA (deferred payment)	49*	49*
Medical Care Cost Recovery	113	826
SSN Death Verification	4	47
HOME LOAN GUARANTY		
a. Decrease defaults/foreclosures-150 FTEEs	100	1,000
b. Include resale losses in net value	80	445
TOTALS	1,094*	5,711*

* Savings as yet undermined resulting from additional months of COLA delay should also be credited.

The VSOs welcome scrutiny of our savings estimates and the analyses supporting them. We are confident that the projected savings are not only real but conservative estimates. Had this information been before Congress, as it would have been in the normal legislative process, it is difficult to imagine that Congress would have enacted Veterans Programs deficit reduction in its present form. Be that as it may, Congress will have a solid deficit reduction alternative that greatly exceeds OBRA's terms and requirements. We urge immediate consideration and speedy enactment of our legislative proposals so that Congress may undo the harm that has been done unfairly to veterans and their families.

The Independent Budget deficit reduction legislative proposals are:

Repeal the following provisions of Title VIII of the Omnibus Budget Reconciliation Act of 1990 which amends Title 38, United States Code and the Internal Revenue Code of 1986.

Subtitle A - Compensation, DIC, and Pensions

Section 8001. Limitation on Compensation for Certain Incompetent Veterans.

Section 8002. Elimination of Presumption of Total Disability in Determination of Pension for Certain Veterans.

Section 8003. Reduction in Pension for Certain Veterans Receiving Medicaid-Covered Nursing Home Care.

Section 8004. Ineligibility of Remarried Surviving Spouses or Married Children For Reinstatement of Benefits Eligibility Upon Becoming Single.

Subtitle B - Health Care Benefits

Section 8012. Copayment for Medication.

Section 8013. Modification of Health-Care Categories and Copayments.

Subtitle C - Education and Employment

Section 8021. Limitation of Rehabilitation Program Entitlement To Service-Disabled Veterans Rated at 20 Percent or More.

Subtitle D - Housing and Loan Guaranty Assistance

Section 8032. Loan Fee.

Subtitle E - Burial and Grave Marker Benefits

Section 8041. Headstone and Marker Allowance.

Section 8042. Plot Allowance Eligibility.

Subtitle F - Miscellaneous

Section 8051. Use of Internal Revenue Service and Social Security Information Data for Income Verification.

1. Under the amendments to Subparagraph (D) of Section 6103(1)(7) of the Internal Revenue Code of 1986, repeal only the phrase, "or any other law administered by the Secretary of Veterans Affairs," contained in (c)(VIII)(I).
2. Under the amendments to Chapter 53, Title 38, United States Code, Section 3117, repeal only subsection(d) GAO Study.

Section 8052. Line of Duty. (Secondary Effects of Willful Misconduct) Repeal in its entirety.

ADDITIONAL LEGISLATIVE PROPOSALS

General

Remove the sunset date in section 8051 and make this provision permanent.

Housing and Loan Guaranty Assistance

Require by law that the resale losses be included in net value for purposes of the formula used to determine whether VA will acquire a foreclosed property.

Compensation, DIC, and Pensions and Education and Employment

Enact the Veterans Claims Administrative Equity Act of 1991 (H.R. 141) which (1) provides for payment of interim benefits when claims are not adjudicated within 180 days, and (2) when eligibility for vocational and counseling services is established but counseling is not provided within 60 days, the bill requires VA to contract for such counseling through accredited agencies. (This provision will be fully discussed in the "General Operating Expenses" section.)

Veterans Insurance and Indemnities

o Increase the maximum face value of Veterans' Mortgage Life Insurance (VMLI) policies from $40,000 to $90,000.

- Provide the availability of $10,000 supplemental life insurance for Service Disabled Veterans' Insurance (SDVI) policy holders who have waiver of premiums in effect.

FUNDING THE COSTS OF THE VSO LEGISLATIVE PROPOSALS

The VSOs' deficit reduction plan will produce savings of $5.711 billion that can be scored as such under OBRA. OBRA calls for savings of $3.35 billion over FYs 1991-1995. VA would retain the additional savings of $2.491 billion within its budget and use it to fund the VSOs' legislative proposals. It would use a small part of retained savings to fund the additional Veterans Benefits Administration (VBA) resources needed to restore adequate delivery of benefits and services to veterans. In addition, in view of the language of Title XIV of OBRA, VA has good reason to anticipate $500 million more in budget authority by FY 1993.

Finally, the VSOs observe that, by legislating a five-year budget planning cycle, OBRA has provided VA management with the fiscal stability essential to finally restore good health care and benefits and services delivery to veterans. The FYs 1991-1995 budget allocations, combined with the additional $500 million in anticipated appropriations and the almost $2.5 billion in savings exceeding deficit reduction targets resulting from the VSOs' recommendations, should provide the necessary resources for good service without *any* entitlement cuts or restrictions. Effective program administration, however, is also necessary, a subject that the "General Operating Expenses" section (which follows) discusses.

[illegible]

GENERAL OPERATING EXPENSES
Principles and Guidelines

- Timely and accurate benefit and service delivery should be an integral element of Congressionally-authorized veterans' entitlement programs.

- GOE appropriations have been and are insufficient to provide adequate benefit and service delivery.

- Congress should establish reasonable expectations for timely and accurate benefit and service delivery.

- Inadequate GOE appropriations unfairly penalize veterans by denying or delaying benefits and services to which they are entitled.

- To ensure that veterans are not unfairly penalized by inadequate GOE appropriations Congress should legislate, as an entitlement, reasonable timeliness standards for benefit and service delivery.

GENERAL OPERATING EXPENSES

INTRODUCTION

In addition to addressing the broad themes of the level of service veterans should be able to expect from VA and the budget process that has failed to provide VA with the resources to deliver adequate service, prior Independent Budgets have included a component-by-component analysis of each GOE account. The VSOs intended this approach and format to mirror the VA budget submission.

The VSOs, however, recognized in prior Independent Budgets our limitations in assessing the FTEE needs of every GOE component, especially those that primarily support internal VA needs rather than direct services to veterans—for example, Executive Direction, Support Services, and most functional areas of General Administration.

Similarly, although we can quantify operations components' FTEE needs (for example, Veterans Services, Compensation and Pensions, Vocational Rehabilitation and Counseling, and Loan Guaranty) and identity areas where additional budgetary support is essential—we have neither the capability nor inclination to quantify independently the costs of integral parts of VA's budget, such as ADP and non-ADP equipment, travel, and other nonpersonnel costs.

Therefore, in this Independent Budget we are departing somewhat from the previous format to focus completely on the areas for which we can make the independent budgetary recommendations Congress wants. We discuss the three major components of GOE (Veterans Benefits Administration, National Cemetery System and General Administration) and provide a FY 1992 budget estimate for GOE in Table 18. Our budget analysis, however, will address two main areas: (1) our assessment of the level of service being provided to veterans by the three major GOE components; and (2) our recommendations for authorizing and appropriation legislation to restore adequate benefits and service delivery to veterans.

THE CHALLENGE

Prior Independent Budgets demonstrated to Congress that VA is not meeting some real veterans' needs because of a series of inadequate VA budgets. The FY 1991 Independent Budget was particularly successful in convincing the House and Senate Veterans Affairs Committees (VACs) that VA needs additional GOE resources to provide adequate service to veterans. Again, however, FY 1991 appropriations did not provide those additional resources; for example, FY 1991 appropriations support fewer VBA FTEEs than FY 1990 appropriations.

As in previous years, then, the challenge is to overcome the barrier that prevents real veterans' needs from being met by adequate appropriations.

VSO STRATEGY

Our strategy is simple: To convince Congress to allow VA to retain a small portion of the internally-generated savings the "Benefits Programs" section describes to fund the additional resources necessary for adequate benefits and service delivery to veterans.

VETERANS BENEFITS ADMINISTRATION

The Veterans Benefits Administration (VBA) administers most of VA's non-medical benefits and services to veterans and their dependents. It does so through 58 regional offices (some of which are medical/regional office centers), and through nationwide toll-free telephone lines. The benefits VBA administers include compensation for service-connected disabilities; pensions for low-income, aged or disabled veterans; vocational rehabilitation; education and training support; home loan guaranties; and life insurance.

Earlier Independent Budgets have analyzed in depth VBA's service delivery problems and the budgetary support it needs to solve them. There is no need to do so again. We must repeat, however, that the VBA workforce is not the problem. As the FY 1991 Independent Budget stated:

> The cruel irony is that, had Congress given VBA managers the minimal budget support they needed to plan and implement a program for staged and orderly productivity growth during the past decade, good service to veterans would have been at least maintained. More than likely it would have improved, and GOE's real-dollar costs would now be less. Perhaps the VSOs are again preaching to the choir, but we must say: Career civil servants are not the problem; they are, in fact, the only means to a solution, if they are allowed to do their jobs.

TABLE 18
General Operating Expenses
(dollars in thousands)

	FY 1990 Approp.	FY 1991 Approp.	FY 1991 Current Services	FY 1992 Current Services	FY 1992 IB Recomm. Authority
Veterans Benefits Admin.	$562,590	$616,658	$616,658	$642,558#	$654,058*#
National Cemetery System	48,236	53,545	53,545	71,900	71,900
General Administration	200,324	232,311	232,311	250,625	250,625
TOTAL GOE	$811,150	$902,514	$902,514	$965,083	$976,583

*Includes $7 million for 195 additional Veterans Services' FTEEs.
*Includes $4.5 million for 150 additional Loan Guaranty FTEEs.
*Includes reimbursements of $142.7 million for administrative costs of implementing OBRA provisions.
#*Does not* include some major appropriations items such as ADP and non-ADP equipment and other non-personnel costs.

The VSOs have been impressed with VBA's responsiveness in implementing Independent Budget recommendations when it has the means to do so, especially in the areas of setting service delivery goals and integrating them within the internal budget process, improving training, and devising and applying innovative interim ADP improvements while moving toward a long-range systems solution.

In the FY 1991 Independent Budget, the VSOs proposed a long-range plan for VBA to restore good service to veterans. The plan required an increase in FTEEs in conjunction with interim ADP improvements to stabilize and gradually improve service. When the integrated VA-wide electronic data processing system is fully operational in 1993 or 1994, service improvement should accelerate. Once good service is restored, FTEE levels could begin to decline.

FY 1991 enacted appropriations are adequate for ADP needs; however, they are not sufficient to support the number of FTEEs VBA needs to improve service to veterans. The FY 1991 appropriated FTEE level of 12,550 is 50 fewer than the FY 1990 appropriated level. The budget and appropriations process unfortunately followed previous years' patterns: The President's budget requested an FY 1991 VBA staffing level of 12,334 FTEEs, a *decrease* of 266 from the FY 1990 appropriated level. The Independent Budget recommended an FY 1991 VBA staffing level of 13,389, and the House and Senate VACs recommended 12,911 and 12,721, respectively.

Although the recommended number of FTEEs varied among the Independent Budget and VACs, there was remarkable agreement that VBA needed a significant increase in FTEEs, primarily for Compensation and Pensions claims adjudication (to improve timeliness and quality), Veterans Services and Vocational Rehabilitation and Counseling. To improve veterans' access to benefits information and outreach programs. There was also agreement that arbitrary productivity "savings" not be spent on reducing FTEE levels but instead be invested in improving service to veterans. The House VAC, for example, specified that the 118 FTEEs that Support Services would lose (based on arbitrary productivity savings) be directed to Compensation and Pensions to improve timeliness. Finally, there was a common recognition of the cost-effectiveness of additional FTEEs in Loan Guaranty.

Typically, these thoughtful and fiscally-responsible recommendations did not survive the appropriations process. The Appropriations Committee Conference Agreement Report "increased" the VBA FTEE level by 216 over the President's budget request, but, again, these are 50 FTEEs fewer than the FY 1990 appropriated level and 131 fewer than the FY 1990 actual. Regardless of the report's language, less is not more, but the conferees proceeded to allocate the 216 "additional" FTEEs by functional areas as follows: "not less than 22 in the vocational rehabilitation and counseling program with the balance of staff to be distributed at the discretion of the VA to loan guaranty and adjudication." Of course, since there will actually be fewer employees, this only means that the FTEE levels for the specified functions would be cut less than in other functions.

Obviously, then, *GOE appropriations will not support an FTEE level adequate to plug the many holes in VBA's* *service delivery dike.* The problem is compounded because, while the FY 1991 budget recognizes that 145 additional FTEEs are required to comply with the "improved decision letters" provision of Section 115 of P.L. 101-237, appropriations have not been provided to support these additional FTEEs. Moreover, because productivity "savings" in the form of FTEEs have not been retained as recommended by the Independent Budget and VACs, there are no additional FTEEs to improve the many areas of deficient service. So, once again, VBA has been told to do more with less.

Reason for hope, however, has appeared just as the VSOs were about to despair that the appropriations process would ever provide VBA with adequate resources. The Omnibus Budget Reconciliation Act of 1990 (OBRA) in general and many of its provisions in particular have loosened the iron grip of the annual appropriations process.

For example, VBA's FY 1991 budget obligations are $25.3 million more than appropriations. This amount represents reimbursements to VBA (from other federal sources and within VA itself) that VBA uses to fund its operation. VBA's FY 1990 obligations included only $4.1 million in reimbursements. We believe most of the $25.3 million in FY 1991 reimbursements are from "amounts available to the Department of Veterans Affairs for the payment of compensation and pension", as authorized by OBRA. Thus, although FY 1991 appropriations support a VBA FTEE level of 12,550, reimbursements support an additional 557 FTEEs, for a total of 13,107 VBA FTEEs. Moreover, beginning in FY 1992, VBA will receive reimbursement from the Loan Guaranty housing appropriation for the costs of administering the Loan Guaranty Program.

Also, in connection with OBRA, VA's budget allocation has been set for FYs 1991-1995. This interjects much-needed stability into the budget planning process. Moreover, reimbursements from non-GOE accounts for administrative costs add flexibility to budget planning. Most importantly, the case can and should be made that internally-generated savings exceeding deficit reduction targets should be retained by VA to improve service delivery to veterans.

Combined, these elements can remove the whipsaw effect that the annual appropriations process has had on GOE components. The FY 1992 VA budget allocations, together with reimbursements and savings exceeding deficit reduction targets that the VSOs have identified in the preceding section should, with some management ingenuity, free up sufficient funding to restore adequate benefits and service delivery to veterans.

This means that a good faith effort can produce funds previously unavailable to VBA. Within this context, the VSOs' assessment of VBA service to veterans and our budgetary recommendations for improving it follow.

ASSESSMENT OF VBA SERVICE TO VETERANS

AUTOMATED DATA PROCESSING (ADP) SYSTEMS MANAGEMENT

The positive trend noted in the FY 1991 Independent Budget regarding ADP Systems Management continues. The pieces have finally come together: There is innovative, goal-directed and action-oriented management; interim improvements are providing more systems support for VBA operations activities; and the long-range systems modernization plan appears to be on track. Not coincidentally, ADP Systems Management activities are receiving adequate budgetary support.

There is one area, however, where systems support is needed quickly. Compensation and pension claims backlogs and timeliness are being adversely affected by the improved decision letter requirements of P.L. 101-237 because VBA has not been provided the FTEEs to perform this additional work. Systems support therefore is essential if further deterioration is not to occur.

Although ADP activities funding appears adequate, with consequent significantly improved systems support for components that provide direct service to veterans, these components' inadequate FTEE levels continue to greatly impair VBA's service delivery to veterans. The VSOs are not alone in this assessment, as the following discussion of VBA's service functions demonstrates.

VETERANS SERVICES

In their reports on the FY 1991 VA budget, both the House and Senate VACs[1] recommended significant FTEE increases to improve telephone access and outreach programs and to provide veterans' benefit counselor (VBC) presence in large metropolitan areas and VA medical centers which lack counselors. The VACs were obviously disturbed by the impact inadequate budgets have had on this critical service function. The House VAC report states:

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[1] The House VAC Report to the Committee on the Budget is contained in Committee Print No. 6, dated February 28, 1990. The Senate VAC submitted its report to the Committee on the Budget by letter dated March 12, 1990. Subsequent quotes and references to the House and Senate VAC reports are taken from these documents.

> Clearly, inadequate budgets deny access to information, benefits and services to thousands of veterans, their dependents and survivors. The committee is determined to correct this situation and, accordingly, recommends that an additional 195 FTEE be provided for Veterans Services. Failure to do so will perpetuate the shameful, back-door method of budget reduction which results when access is limited at the intake point, thus reducing the number of veterans' claims which enter the system.

The Senate VAC recommended an additional 120 FTEE, recognizing that this would only ameliorate and not solve the problem, yet appropriations provided no additional FTEEs above the budget request. Veterans Services was not one of the Appropriations Committee's designated recipients of the 216 "additional" VBA FTEEs over the President's budget request. Thus, the House and Senate VACs' recommendations, like the VSOs', went for naught.

Veterans deserve the same level of service as Social Security recipients and applicants.

We should note that VA's FY 1991 budget request for Veterans Services reflected a 15-FTEE decrease (from 2,081 to 2,066) from the FY 1990 level. However, 20 additional FTEEs were provided to handle the telephone workload. (At the Senate VAC budget hearing, held on February 23, 1990, VA testified that an additional 54 FTEE would be needed to achieve VA's acceptable service standard—that is, 81 of every 100 persons who attempt to call receive service.) The net decline in Veterans Services FTEEs reflected a reduction of 41 FTEEs associated with the implementation of modernization short-term initiatives. It is unconscionable that these 41 FTEEs vanished, rather than being used for the telephone workload.

The "Benefits Program" section discusses the contrast between the levels of service Congress expects and is willing to provide by appropriations for Social Security and VA telephone access and personal contacts. How can Congress justify this disparate treatment? Surely, veterans deserve the same level of service as Social Security recipients and applicants.

Obviously, VBA will not be able to provide such service with FY 1991 appropriations. Moreover, current laws put additional strain on Veterans Services' limited resources. The OBRA provision limiting the estates of incompetent veterans (the VSOs advocate repeal of this provision) and the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP) instituted by P.L. 101-237 have significant impact on Veterans Services. Where will the FTEEs to implement this legislation come from?

Veterans Services has a number of planned initiatives to improve services, but they require resources that Congress has been unwilling to provide. The VSOs believe that Veterans Services needs the 195 additional FTEEs recommended by the House VAC just to be able to provide (1) VA's standard for acceptable telephone access; (2) at least one VBC in each large metropolitan area and in each VAMC; and (3) support for the TAP/DTAP programs. Veterans Services also needs funds for additional phone lines, training, equipment, and technologies to aid benefit information dissemination.

ADJUDICATION

The House VAC report on the FY 1991 VA budget states:

> As of the end of fiscal year 1989 only 26.7 percent of original compensation claims were being processed within 90 days. This is well below the Department's minimal acceptable level of 35 percent and far below the level the Committee believes the Department should be considering as acceptable, 50 percent. The budget request acknowledges the need for appropriate staffing levels in order to maintain its current performance levels, but it remains to be seen whether the Department will be able to make significant inroads towards timely and accurate claims processing.

As it turns out, the record justifies the House VAC's doubts about whether VA could make significant inroads toward timely and accurate claims processing. In FY 1990, VBA processed 26.6 percent of original compensation claims within 90 days. Moreover, the percentage of claims not processed within six months increased from 31.2 percent in FY 1989 to 32.3 percent in FY 1990.

The size of the compensation and pensions claims backlog has been a matter of some controversy. In the FY 1991 Independent Budget, the VSOs calculated the backlog independently, using VA reports that showed cumulative 12-month claims receipts and dispositions. VA challenged the VSOs' backlog figure, stating that it was not 654,392, as the Independent Budget indicated, but rather 343,199. The VSOs met with VA management officials to resolve the issue. VA acknowledges that there is a problem in its reporting system but maintains that its reported pending claims data are accurate. VA is taking steps to identify and correct the reporting problem (which they believe is due to double counts). The September 30, 1990, backlog reported by VBA is 377,767. Regardless of the size of the backlog, the timeliness of case processing is still dismal.

If VBA processed claims in a timely manner, the size of the pending workload would little concern the VSOs. Congress, however, has not provided VBA with enough FTEEs to make the inroads toward timely and accurate case processing that the VACs and VSOs desire. The VSOs are therefore seeking authorizing legislation to mandate reasonable timeliness of claims processing as an entitlement. We will discuss this fully under "Recommendations".

VOCATIONAL REHABILITATION AND COUNSELING (VR&C)

The need for additional FTEEs to provide VR&C services to service-connected disabled veterans has been recognized for years. The situation was ably and accurately described in the House VAC report on the FY 1991 budget:

> VR&C program data indicate increasing service workload. FTEE reductions which occurred in earlier years, in spite of Congressional efforts to correct the decline, have resulted in unreasonable caseloads for vocational rehabilitation specialists (VRSs). The average VRS workload has steadily increased to 220 cases at the end of FY 1989. A reasonable load is approximately 150 with a workload of 120 being the ideal. Thirty-eight stations show a VRS workload in excess of 200. In order to maintain an acceptable level of quality services, the CP (counseling psychologist) workload is maintained at a relatively constant level, but this results in delays for those veterans who have not yet begun the evaluation process.
>
> FTEE reductions and increased workload have resulted in increased time in Applicant and Employment Status for disabled veterans seeking assistance. Applicant Status is the average number of days from date of receipt of Chapter 31 applications in DVA to the date the veteran keeps his or her first appointment in the VR&C Division. A veteran enters Employment Status when he or she is determined to be "job ready" and is maintained in this status a minimum of 60 days after becoming employed. Time in applicant status has steadily increased. From an average of 78 days in FY 1985, the average increased to 100 days in FY 1989, and 19 of 57 DVA stations exceed that waiting period. This delay is extremely disturbing because studies of effective vocational rehabilitation programs repeatedly show the importance of starting rehabilitation quickly before negative attitudes about employability become established. Time in employment status increased from 155 days in fiscal year 1984 to a waiting period of 285 days in fiscal 1989. As provided in Chapter 31, Title 38, USC, the VR&C program is intended to enable service-disabled veterans to become employable and to obtain and maintain suitable employment. The excessive time in employment status indicates that employment services required under Chapter 31 are not being effectively provided.

The House VAC report goes on to cite the FY 1991 Independent Budget analysis regarding the cost-effectiveness of the program because of the increased taxes paid by rehabilitated veterans on their greatly increased earnings. The report states: "This results in an increase in tax revenues of approximately $3,500 per rehabilitated veteran per year and a decreasing reliance on public assistance programs. The VR&C program returns dollars to the Treasury and, with improved resource levels, could be expected to improve its success rate."

The House VAC concluded:

> Because vocational rehabilitation services carry out our nation's commitment to those to whom we owe the most, service-connected disabled veterans, it is imperative that services provided under the VR&C program meet the highest standards of timeliness and quality. In order to accomplish this, the Committee rejects the Administration proposal that FTEE in VR&C be reduced and recommends that 69 additional FTEE be provided for this service. This staffing increase would reduce the average VRS caseload to 135 active cases, a level above that for comparable staff in the state/federal rehabilitation program, but nonetheless a significant improvement over the current unmanageable caseload.

The Senate VAC report on the FY 1991 VA budget reached similar conclusions:

> Because vocational rehabilitation services directly represent our nation's commitment to service-connected disabled veterans—those whose sacrifices deserve the highest priority—it is imperative that services provided under this program meet acceptable standards of quality and timeliness. At the same time, vocational counseling professionals have established that the substantial lag time between applications for services and initial face-to-face

> counseling contact has two adverse effects. First, the applicant's level of motivation and morale is reduced as delays produce the impression that the system is unresponsive and uncaring. Second, a person who has become disabled is prone to depression and an increase in psychosomatic symptoms, a tendency exacerbated by lengthy delays. Both of these adverse effects render more difficult the achievement of the primary objective of vocational rehabilitation—veterans' successful re-entry into competitive employment—and thus prevent these veterans from becoming more productive, contributing members of society and taxpayers. (Add 73 FTEE.)

OBRA, of course, has provided a solution of sorts: reduce the workload by approximately one-third by limiting VR&C services to service-connected disabled veterans rated 20 percent or more. The VSOs strongly oppose this provision and are seeking its repeal. At the same time, however, the VSOs recognize that the appropriations committees have not provided the GOE resources recommended by the VACs that are necessary to have this program function effectively. Paradoxically, OBRA contains specific direction from the House Democratic leadership, working with the Congressional Black Caucus, targeting a portion of the $500 million to be added to the VA's budget by FY 1993 for Rehabilitation. The VSOs also are recommending authorizing legislation to make timely VR&C services an entitlement (see below under "Recommendations").

LOAN GUARANTY

This program has been discussed at length in the Benefits Program section. In GOE, it is important to emphasize that good things have been happening with the program's administration. All indicators for FY 1990 show major improvements. Compared to FY 1989, the number of defaults reported declined from 171,295 to 163,959, and the number of defaults pending declined from 126,877 to 116,522. The number of personal contacts increased from 163,576 to 182,199, and the number of successful interventions increased from 3,123 to 5,400. Of particular significance is that the Foreclosures Avoidance with VA Involvement Ratio (FAVIR) increased from 2.8 percent to 4.6 percent. (FAVIR includes successful interventions plus refunding, plus voluntary conveyances, divided by defaults reported.)

This improved performance occurred during FY 1990, hardly a banner year for the economy or the real estate market. Thus, the results cannot be credited to good times or good luck. The improvement occurred, despite unfavorable economic and market conditions, because of good management practices, enhanced ADP support, and additional FTEE deployment for the loan service and claims and property management functions. The correlation between additional FTEEs and program savings is described in the FY 1991 VA budget request under Loan Guaranty's "Assessment of Services Provided to Veterans":

> In addition, the current 1990 estimate includes 244 FTEE targeted for the loan service and claims and property management functions. These FTEE will greatly improve upon VBA's ability to service delinquent GI and portfolio loans and dispose of acquired properties at higher prices. Approximately 166 FTEE will be allocated to selected field stations, e.g., Houston, Waco, and Denver, to aggressively service defaulted loans. At this staffing level, loan guaranty personnel will be able to attempt to make personal contact with every borrower in default. VBA expects to intervene successfully with lenders to develop forbearance arrangements and repayment plans. In addition, the field stations will have the extensive man-hours necessary to work on compromise claims, refunding and voluntary conveyances.
>
> VBA will also add 78 FTEE to the Property Management function in 1990 to concentrate on more effective marketing of properties. This will be accomplished by repairing properties in housing markets where VBA can obtain significantly higher prices (over expenses) than if the properties were disposed of in the "as is" condition. Our goal is to continue property inventory reduction while reducing the average loss per sale.

In the "Benefits Programs" section, the VSOs recommended 150 additional FTEEs for the Loan Guaranty function. Under OBRA's credit reform provisions the costs would be funded by reimbursements from the LGRF.

OTHER COMMENTS AND OBSERVATIONS ON VBA PERFORMANCE

The insurance function continues to be administered excellently, and in this regard, the VSOs intend "to leave well enough alone."

A major issue VBA must address is the budgetary and service impact of so-called "productivity savings." In their reports on the FY 1991 VA budget, the VACs joined the VSOs in criticizing the practice of justifying cutting FTEE levels, especially in the Support Services area, by citing productivity savings, even while direct service to veterans deteriorated or, at best, continued at unacceptable levels. It is time for VA in general and VBA in particular to join the VACs and VSOs in forcefully opposing this practice. The budget deficit reduction environment that the Budget Enforcement Act of 1990 created and the setting of the FYs 1991-1995 VA budget allocation effectively remove such internally-generated savings from the appropriations process and permit their retention for improving service.

In the past, the VSOs (and, we suspect, the VACs) have been skeptical as to whether productivity savings were actually occurring. This is no longer so; improved management and ADP modernization are generating quantifiable productivity savings, and there is reason to believe that these savings will accelerate as systems modernization progresses. This being so, the need for *additional* FTEEs provided by GOE appropriations may well decrease. This is all to the good, since the appropriations process has not provided resources to meet veterans' needs.

The VSOs' intent is not to increase the number of FTEEs; it is to ensure that there are a sufficient number to provide good service to veterans. It does not matter, for example, where the additional FTEEs needed to provide benefit information personally or by telephone come from, as long as they exist. If FTEEs can be found as a result of productivity savings in other VBA areas, so much the better—as long as service does not suffer elsewhere.

VBA has shown that it can quantify productivity savings in terms of FTEEs. It can also quantify the number of FTEEs it needs to provide acceptable service. The VSOs urge that the VBA-wide FTEE savings generated by productivity gains be retained and applied to functions to improve service. This will minimize the number of *additional* FTEEs VBA needs to achieve acceptable service. Savings in excess of deficit reduction targets, which the VSOs' Deficit Reduction Plan identifies in the "Benefits Programs" section, can easily fund these additional costs.

RECOMMENDATIONS

Given the above service delivery assessment, VBA needs additional FTEEs to perform the Veterans Services, adjudication, vocational rehabilitation and counseling and loan guaranty functions. However, except for additional Veterans Services FTEEs, the VSOs recommend alternative (that is, non-GOE) funding sources to provide the minimum level of service to which we believe veterans are entitled. Our specific recommendations follow.

PROVIDE 195 ADDITIONAL FTEES FOR THE VETERANS SERVICES FUNCTION THROUGH GOE APPROPRIATIONS

We described our rationale for this recommendation above. It is important to emphasize that the additional FTEEs are needed merely to meet VA's "acceptable" telephone service standard and to begin to fulfill some of the Congressionally-mandated outreach and personal contact service expectations.

In addition, the VSOs encourage the VACs to examine the VA standard that considers service acceptable if 81 of 100 veterans are able to reach a veterans' benefits counselor by telephone. We urge the VACs to compare this to Congressional expectations for service provided by the Social Security Administration. The VSOs believe that Congress should expect VA to deliver the same level of service and should therefore provide VBA with sufficient resources to meet those expectations.

PROVIDE 150 ADDITIONAL FTEES FOR THE LOAN GUARANTY FUNCTION, FUNDED BY THE LOAN GUARANTY REVOLVING FUND

This recommendation is an important part of the VSOs' Deficit Reduction Plan and is fully explained above.

LEGISLATE AS AN ENTITLEMENT REASONABLE TIMELINESS STANDARDS FOR THE ADJUDICATION OF COMPENSATION AND PENSIONS CLAIMS AND DELIVERY OF VOCATIONAL REHABILITATION AND COUNSELING SERVICES

In prior Independent Budgets, the VSOs have set service delivery goals representing the minimum acceptable service level for each VBA component, analyzed the resources required to meet these goals, and made appropriations recommendations accordingly. We have repeatedly made the obvious point that this is exactly what the budget/appropriations process should be all about. This, however, has been an exercise in futility because, at the critical point of appropriations, Congress has refused to make the connection between minimum service delivery expectations and the resources needed to meet them. In fact, throughout the past decade, the appropriations process has operated as if minimum service delivery expectations were not a factor in determining resource needs.

Like it or not, however, *the level of enacted appropriations has implicitly defined Congressional expectations for benefits and service delivery.* Veterans and, we are sure, VA are not at all satisfied with these unstated but nonetheless real Congressional expectations. The VSOs want Congress to formalize in legislation their expectations for VA's delivery of authorized benefits and service entitlements.

Because the appropriations process has been so unresponsive, the VSOs are convinced that this is the only way to interject some element of accountability into the process and ensure some degree of equity for veterans. This is not an entirely new concept: the legislative vehicle to implement it already exists.

THE VETERANS' CLAIMS ADMINISTRATIVE EQUITY ACT OF 1991

This legislation was first introduced by Congressman Bob McEwen (R., Ohio), a member of the House Veterans Affairs Committee, on October 4, 1990. Congressman McEwen re-introduced an identical measure in the 102nd Congress re-introduced (H.R. 141) on January 3, 1991. The VSOs fully support this legislation. Its main provisions are:

> S.3117 Payment of benefits on interim basis when claims not decided within specified time limit
>
> (a) If a claim for compensation, dependency and indemnity compensation, or pension is not decided by the Secretary within 180 days of the date on which the claim is filed, the Secretary shall pay benefits in accordance with the claim until the claim is adjudicated. Such benefits shall be paid effective on the first day of the first month beginning after the end of such 180-day period.
>
> (b) In a case in which a claim described in subsection (a) is denied in whole or in part and the claimant files a Notice of Disagreement with the Secretary, if the Secretary does not certify the case to the Board of Veterans Appeals within 180 days of the date of the filing of the Notice of Disagreement, the Secretary shall pay the benefits for which the claim was filed in accordance with the claim. Such benefits shall be paid effective on the first day of the first month beginning after the end of such 180-day period.
>
> (c) Whenever the Board of Veterans Appeals or the Court of Veterans Appeals remands a case to the Secretary involving claim for benefits described in subsection (a), the Secretary shall pay benefits in accordance with the claim retroactive to the first day of the first month beginning after the month in which the decision appealed from was made.
>
> (d) Payments made pursuant to subsection (a), (b), or (c) shall terminate effective on the last day of the month in which a decision resolving the claim is made.
>
> (e) Any payment made pursuant to this section shall not be considered to be an overpayment and shall not otherwise be subject to recovery by the United States.
>
> (f) In any case in which a veteran, having been determined to be eligible for vocational rehabilitation and counseling services under chapter 31 of this title, is not interviewed by the Secretary within 60 days after the date of such determination, the Secretary shall arrange for the provision of vocational rehabilitation and counseling services for the veteran to be provided through an accredited agency or institution (other than the Department) on a fee basis.
>
> (g) Not later than February 1 of each year, the Secretary shall submit to the Committees on Veterans Affairs of the Senate and House of Representatives a report on the operation of this section during the preceding fiscal year. Each such report shall describe--
>
> 1) the ability of the Department during that fiscal year to meet the timeliness standards established by this section;
>
> (2) the amount of benefits paid pursuant to this section during that fiscal year; and
>
> (3) any recommendations of the Secretary for modifications to the timeliness standards established in this section, together with justification for such recommendations.

In introducing the bill, Representative McEwen stated:

> As many of you know, I have often expressed my frustration with the level of service accorded to veterans who file claims for benefits. Too often, these claims take too long to settle. While some claims are adjudicated in a matter of months, others can go on for years. We've held hearings on claims timeliness and quality, and we've covered the subject during budgets discussions. The frightening statistics on claims backlogs within the Department of Veterans Affairs lead one to fear some claims may never be decided. That is inexcusable.
>
> It may be time to enact a law to require the

Department of Veterans Affairs (VA) to do whatever is needed to speed up the processing of veterans claims. I have grown tired of pleading with the VA to make internal improvements to become more responsive to veterans seeking vitally needed services. Clearly, a statutory approach, with reasonable deadlines, should be explored.

Today, I have introduced the Veterans' Claims Administrative Equity Act of 1990 with that thought in mind. I hope the message is clear—that it is time to get a handle on the delays and backlogs which have bogged down veterans' claims processing and denied benefits to deserving veterans. The Veterans Benefits Administration, for all its many hundreds of dedicated employees and automation, continues to fall short of the expectations of this Committee and, most important, the veterans it was established to serve.

Throughout the veteran population, it might be assumed that the level of service to veterans now yielded under the present system is the type of service that is intended by the Congress, and this Committee. That assumption ignores the present reality, because the system is falling short of my reasonable expectation and, I suspect, those of many of my colleagues.

We need to mandate veterans' claims reform. My legislation would establish strict timeliness requirements on the Veterans Benefits Administration. The bill is not complicated. It directs that an initial claim for benefits must be decided in 180 days from the date filed. That is not unreasonable. For initial claims that are denied and for which the claimant files a notice of disagreement, the Secretary of Veterans Affairs would be required to certify the case to the Board of Veterans Appeals within 180 days.

This bill has teeth, establishing needed incentives for the Veterans Benefits Administration to handle claims efficiently. It would provide for the paying of interim benefits to claimants in cases where the VBA could not meet the deadlines I just outlined. However the case is ultimately decided, any interim benefit paid to a veteran would not be subject to recovery by the Department. This small accommodation by the government cannot fully compensate for the uncertainty and hardship accompanying the veteran's long wait for service.

I would apply the proposed timeliness standards to all compensation, dependency and indemnity compensation, and pension claims. In addition, this legislation addresses the problem—not uncommon—in which a veteran has been found eligible for vocational rehabilitation and counseling services and is not served in a reasonable time. In those cases where eligibility for these services is established and an interview with Department officials is delayed beyond 60 days, the Secretary shall arrange for this invaluable assistance through an accredited agency. These services enable veterans to reenter the workforce as productive citizens, a process that should not be hampered by bureaucracy.

I believe that a benefit or service to which a veteran is entitled is eroded considerably when it is not delivered in a reasonably timely way. My bill defines objectives for timeliness, in the interest of a larger goal: serving the deserving veteran.

The veterans' claim problem has not been a case of missed targets, because there have been no minimum satisfactory standards for which to strive. It is common sense that when you don't know what you're aiming for, you're probably going to miss the target.

The VSOs believe this bill is a major breakthrough. It would end the stranglehold OMB and the appropriations committees in general have had on the budget process, by making reasonable service expectations the baseline for budget formulation. As we see it, enactment of the bill would serve several purposes. It would:

(1) Recognize in equity and law that veterans and their survivors and dependents are entitled to have VA decide their claims within reasonable time limits;

(2) Compel Congress to define the minimum level of services it expects VA to provide veterans and their survivors and dependents in deciding their claims, given existing budgetary constraints; and to periodically modify those expectations, as necessary and appropriate;

(4) Provide equity in a meaningful way to individuals whose claims are unduly delayed through no fault of their own, and impose a penalty on VA if a claim is not decided within a specified time;

(5) Provide VA an incentive to develop claims adjudication policies and procedures that enable VA to use existing and planned resources to decide claims as effectively and fairly as possible;

(6) Establish commonly-recognized standards of service delivery, which will enable Congress to discharge its oversight and appropriations responsibilities more effectively.

The timeliness standards set in the bill are, we believe, reasonable by any definition. If VA meets those standards, the bill has no associated costs. Indeed, this is the goal. If VA does not meet the standards, the interim benefits are a small price to pay for the years of budgetary neglect to which veterans have been subjected. In any event, the VSOs suspect that since the bill's penalties and incentives are directed toward timely service, the associated interim benefits costs will be minimal and will quickly decrease. Reasonably timely service being an entitlement, interim benefits would be paid from the Compensation and Pensions and Readjustment Benefits entitlement accounts.

NATIONAL CEMETERY SYSTEM (NCS)

The National Cemetery System is funded by the General Operating Expenses (GOE) appropriation and carries out four main activities. It inters deceased veterans as well as deceased active duty members of the Armed Forces, their spouses, and certain dependents, in national cemeteries that have available grave space; it provides headstones for these burials in national cemeteries and also for burials in private cemeteries; it administers the program of grants to states for state veterans cemeteries; and it prepares and issues Presidential Memorial Certificates to surviving family members and others who request them.

Management of the national cemeteries, as well as the procurement of headstones and grave markers, is provided by a Central Office staff. Immediate supervision of the cemetery installations is accomplished through three National Cemetery Area Offices (Atlanta, Georgia; Philadelphia, Pennsylvania; and Denver, Colorado).

ASSESSMENT OF SERVICE

In prior Independent Budgets, the VSOs have been complimentary about NCS's management. We remain so. NCS does much with little. An observation in the House VAC Report on the FY 1991 VA Budget illustrates this:

> It should be noted that from 1983 to 1990, interment and grave site maintenance workloads have increased 35.4 percent and 19.1 percent respectively. During the same period, the increase in staffing has been only 2.8 percent.

The House and Senate VACs are as impressed as the VSOs with NCS's proven ability to administer this program as efficiently as possible, given its resources. The FY 1991 appropriations process, however, was not kind to NCS.

VA's FY 1991 budget request of $54.8 million was clearly inadequate because, among other things, it did not address a growing equipment purchase and maintenance backlog. In testimony before the VACs, VA stated that it needed additional funds to purchase equipment, ranging from simple items such as grass trimmers to large items such as backhoes and trucks. Funds were also needed for maintenance and repair and to purchase supplies and materials such as fertilizer and seed, which were exhausted. Funds for watering were often not available. The combined effect of this was that the appearance of some cemeteries had fallen far short of appropriate standards.

Consistent with the Independent Budget recommendations, both the House and Senate VACs recommended significant increases over VA's appropriations requests. (The Senate recommended an increase of $14.4 million and the House recommended a $15 million increase.) The House VAC's breakdown of the recommended increases was as follows:

Personal services—100 FTEEs	$3 million
Replacement equipment backlog	$7 million
Maintenance and repair projects deferred	$1.3 million
Supplies and materials shortfall	$1.2 million
Utilities (water)	$800 thousand
Equipment and supplies for activation of new cemeteries	$600 thousand
Additional equipment for increased workloads	$1.1 million
TOTAL	$15 million

Thus, a total of $69.8 million (VA's request of $54.8 million plus $15 million) was needed to enable the efficiently-managed NCS to restore and maintain the cemetery system to adequate standards. After the appropriations dust settled, however, NCS received $53.5 million. This is simply disgraceful. Congress apparently is willing to see the National Cemetery System reduced to potters' fields.

RECOMMENDATIONS

In addition to the revenues needed for the items mentioned in the House VAC Budget Report, there is a $2.1 million shortfall in deferred maintenance and repair. Therefore, for FY 1992 the VSOs recommend an NCS appropriation of at least $71.9 million, an increase of $18.4 million over the FY

1991 appropriated level. This recommendation may understate NCS's needs because it addresses only the FY 1991 appropriations shortfall. The VSOs are not in a position to quantify the additional FY 1992 resources NCS needs to restore adequate national veterans cemetery standards.

GENERAL ADMINISTRATION

Under General Administration, GOE appropriations fund the activities of the Office of the Secretary, General Counsel, the Board of Veterans Appeals and the Board of Contract Appeals. The functions of the offices of the six Assistant Secretaries are also funded under GOE.

The VSOs have no specific recommendations to make regarding General Administration; however, we do have some observations.

The area within General Administration that has the greatest direct impact on veterans is the Board of Veterans Appeals (BVA). There is a major timeliness problem in processing appeals but this primarily is regional office-related and not attributable to BVA (see GAO Report, GAO/HRD-90-62 - "Improved Management Needed to Reduce Waiting Time for Appeal Decisions," May 1990). The McEwen Bill addresses this problem by imposing timeliness standards which, if not met, will result in interim benefits being paid until the claim is decided.

As with initial claims, this is the best solution because it places the burden where it properly belongs—with VA and not the veteran—to achieve reasonable claims processing times. VA, acting with Congress, will have to determine the FTEE levels and other resources it requires to meet reasonable timeliness standards. If requested and appropriated resources prove to be insufficient, VA and not the veteran will pay the penalty.

MEDICAL PROGRAMS

MEDICAL CARE PROGRAM
Principles and Guidelines

- The VA medical care program is, and has always been meant to be, a health care system for veterans. Authorized beneficiaries are veterans, active duty and retired military, and, by special entitlement, dependent survivors of certain veterans. The veterans service organizations that author the Independent Budget affirm and resolve that access for direct medical care should not be open to others.

- For the past four years, the VSO sponsors of the Independent Budget have advocated the expansion of entitlement for Category A veteran patients. The recommendation not only called for unrestricted hospital care, but also unrestricted outpatient and long-term care. This concept of assured access to a full continuity of medical care for clearly entitled veterans, as well as for non-service-connected medically indigent patients, is so important and timely that we now list it as the *sine qua non* of our principles and guidelines for VA medical programs.

- Separate budget line items should identify high-cost equipment-based technology. A plan to distribute the technology effectively throughout the VA health care system should accompany the budget line item. VA should locate hi-tech diagnostic and therapeutic programs only where they can meet workload volume standards. Where opportune, VHSRA should participate in equipment sharing arrangements to ensure efficiency and improved geographic access. Finally, VA should replace such high-cost, hi-tech equipment according to schedules that accurately recognize its changing character and obsolescence. Appropriate equipment replacement is essential to state-of-the-art medical care.

- Considering the interdependent nature of the nation's pluralistic health care systems, VA strategic planning should take greater cognizance of the dynamics and trends in the private medical sector and adjust to their impact.

- VA must aggressively prepare for the special needs of aging veterans. It must more swiftly convert excess hospital capacity to meet the increasing demand for nursing home care, outpatient clinic expansion, functional rehabilitation, and other extended services. With proper expenditure of effort and resources, VA can and should be in the vanguard of geriatric and long-term care.

- VA needs to make completion of its automated management information network a higher priority. Never has reliable on-line data retrieval been so important to a health care system's strategic planning and sound management.

- Congress must provide funding for cost increases due to inflation. The inflation index for increments in the VA Medical Care budget should reflect actual increases in the health care industry's cost indices.

- Budget submissions should accurately reflect resources needed to activate newly-constructed health care facilities. Congress and OMB should assure that these resources are provided *in full* as the facilities are opened.

- Adequate appropriations for implementation should accompany enacted legislation that creates new health care initiatives. Otherwise, implementation should be at the Department's discretion.

- Congress should categorically exempt appropriations for any federal patient care programs from future federal budget sequestration. This is altogether reasonable for the VA health care system, the integrity of which is vital to its mission as the on-line backup to military medicine.

- VA medical programs should not be expanded, except to meet the needs of Category A veterans.

Medical Care

The Medical Care appropriation provides for the delivery of health care in VA medical centers and other VA and non-VA health care facilities. This care includes inpatient hospital care, outpatient care at hospitals and free-standing clinics, institutional long-term care in nursing homes and domiciliaries, and several types of non-institutional long-term care. The Medical Care appropriation also covers the costs of large-scale education and training programs conducted in VA health care facilities. In addition, the Medical Care appropriation provides for entitled veterans' care in non-VA hospitals, nursing homes, domiciliaries and physicians' offices, in the special circumstances under which VA is authorized to pay for such care. This portion of the health care program consumed approximately 10 percent of the FY 1990 Medical Programs budget.

THE CHALLENGE

Maintaining eligible veterans' access to quality care and meeting aging veterans' needs are the VA Medical Care program's challenges.

THE IMPACT OF BUDGET SHORTFALLS

Past Independent Budgets have included statements of concern regarding deteriorating VA medical care quality. Inadequate resources have resulted in shortages of staff, supplies, and equipment, delays in prosthetic services and outpatient clinic appointments, and rationing of nursing home care. Annual funding shortfalls are particularly destructive because they are applied to a chronically eroding resource base.

Evidence to substantiate these conclusions was obtained through telephone surveys in connection with the construction of the FY 1990 and 1991 Independent Budgets. Another survey was conducted in the course of developing this FY 1992 Independent Budget. It revealed a continuing story of hospital administrators absorbing budget shortfalls by postponing needed equipment replacement, eliminating programs, and rationing care. These forced practices do not translate into quality health care delivery.

We have, however, ample evidence that VA medical center (VAMC) staffs are conscientiously doing their best with the material shortages at hand. We think it deceptive and destructive for television news shows to focus on isolated perceptions of patient neglect, indicting the entire system in the process. Staff insensitivities undoubtedly do occur, but the thousands of dedicated employees who are very caring in their service to veteran patients should be commended.

RESULTS OF TELEPHONE SURVEY

During late November 1990, the Independent Budget staff conducted its third telephone survey. We contacted representative VAMCs across the country. Survey questions were again designed to elicit information on any continuing impact of budget shortfalls in FY 1990, along with expectations for the current fiscal year.

The similarity of facility reports was striking. Findings are presented in a summary fashion and without attribution:

- VAMCs again absorbed shortfalls ranging from $1 million to $4 million per facility in FY 1990. To meet the medical care need, centers redirected funds originally intended for equipment purchase, contract medical service (especially nursing home care and fee-basis ambulatory care), personnel salaries, and building maintenance.
- Most hospitals still report backlogs of needed but unpurchased equipment, ranging in total value from $1 million to $8 million per facility. This equipment backlog has made it difficult in many instances to maintain state-of-the-art patient care. One chief of staff estimated that more than $35 million worth of onboard heavily used equipment would reach obsolescence during the next five years, a situation which he believed to be not uncommon throughout the VA health care system.
- Outpatient clinic appointment waiting times of more than three to four months were widely reported. Certain specialty clinics in some VAMCs had appointment backlogs of up to nine months. Consistently, the explanations revolved around staff shortages, aggravated in some instances by call-up of military reserve physicians and nurses. Some directors also cited insufficient equipment, such as computerized axial tomography scanners, to meet both the inpatient and outpatient workloads.
- Nurse vacancies existed in every facility contacted. Most hospitals had 20 to 50 unfilled positions, especially involving intensive care units. Some directors reported their inability to compete with salaries in surrounding communities, despite special pay incentives.

- VAMCs have similar difficulties recruiting certain physician specialists, for example, anesthesiologists, radiologists, and orthopedists. Delay in Congressional authority for VA physician pay increases aggravates this situation. Staff morale is low in all hospitals as a result of employees' awareness that expected budget shortfalls will result in further reduction of FTEEs and services.

- Medical centers are concerned that the centrally managed prosthetic funds at VA Central Office will not meet systemwide needs because of projected 1991 budget shortfalls.

- Most hospitals report long delays in scheduling elective surgery. One VAMC has a waiting list of 280 herniorrhaphies, averaging more than six months' delay. Some survey respondents reported routine disapproval for high-cost elective surgical procedures.

- One large tertiary care hospital reported increasing inability to accept transfer patients from referring regional VA facilities. The latter, in turn, are resorting to use of high-cost, fee-based, private community medical facilities.

- Because of inadequate activation funding, newly constructed additions at several hospitals have been unable to open all beds.

- Recent attention to military contingency plans in connection with Operation Desert Storm has raised concerns about VA medical centers' ability to provide backup to the Department of Defense.

- Many of those surveyed reported a growing demand for long-term care, and the impossibility of meeting that demand with available resources.

The above findings were similar to those elicited by the House Veterans Affairs Committee (HVAC) in its August 1990 questionnaire, to which 160 VAMCs responded. Aggregate numbers from that survey indicated that the percentage of operating beds that are closed has increased from 25 to 32 during 1990. The HVAC survey also found a marked decrease in nursing home census and prolonged clinic waiting times.

Survey findings indicate that many deficiencies in the VA health care system, which were the subject of special hearings before the Congressional Veterans Affairs Committees in the Fall of 1988, remain uncorrected. Further, the results of the survey suggest that more veterans' health care needs are going unmet as demand is further suppressed by resource constraints.

ACCESS BARRIERS

The VA health care system was once distinguished for offering patients a comprehensive, coordinated continuum of care. Because of budget shortfalls and confusing entitlement rules, many Category A veterans, who have clear entitlement to inpatient care according to Title 38 of the U.S. Code, are not entitled to outpatient care. (See Appendix B for a explanation of Title 38 entitlement and eligibility rules.)

VA health care officials indicate that most VA medical centers are reducing access to ambulatory care through restrictive use of the "obviate the need" clause in Title 38. VAMCs make this dollar-driven decision irrespective of physicians' professional judgements. Many facilities, because of inadequate resources, give care to medically indigent non-service-connected patients only in emergencies.

> *The thousands of dedicated employees who are very caring in their service to veteran patients should be commended.*

Basing decisions to provide or deny medical care on a financially motivated interpretation of the "obviate the need" clause leads to mismanagement of chronic illnesses. It is bad medicine and bad economics to turn away patients who need outpatient care on the grounds that their current condition is not sufficiently severe to require hospitalization. It invites acute, serious and costly complications. It also contradicts the current universal emphasis on non-institutional care and preventive medicine. Ironically, whereas the Category A, medically indigent, non-service-connected veteran still has clear entitlement to all inpatient treatment, he has recently lost access to many procedures now shifted, under cost containment pressure, to an ambulatory setting.

THE IMPACT ON WORKLOAD

Table 19 presents a profile of VA medical care workload for the years 1988-1990. Comparing the numbers of VA hospital inpatients treated in FY 1990 with the Independent Budget's conservatively projected workloads indicates that 100,000 fewer patients were treated than would have been expected. For ambulatory care, 2.3 million fewer patients than would have been expected were treated in FY 1990. Clearly, inadequate funding has compromised veterans' access to care. While some of the reduction in the number of patient days of hospital care is the result of increased delivery of care in outpatient settings, most of the decline represents suppressed demand.

TABLE 19
Selected Comparisons of VA Medical Care Activity Volume
FYs 1988-1990

ACTIVITY	FY 88	FY 89	% CHANGE FYs 88-89	FY 90	% CHANGE FYs 89-90	% CHANGE FYs 88-90
Total Hospital Patients Treated	1,116,681	1,053,942	-6.0%	1,016,430	-3.7%	-9.9%
Non-VA Hospital Patients Treated	27,377	23,655	-15.7%	20,968	-12.8%	-30.6%
State Home Hospital Patients Treated	2,843	2,706	-5.1%	2,404	-12.6%	-18.3%
VAMC Patients Treated	1,086,456	1,027,581	-5.7%	993,058	-3.5%	-9.4%
VAMC Psychiatric Patients Treated	214,512	201,432	-6.5%	191,469	-5.2%	-12.0%
VAMC Surgical Patients Treated	290,569	272,630	-6.6%	262,442	-3.9%	-10.7%
VAMC Medical Patients Treated	581,375	553,519	-5.0%	539,147	-2.7%	-7.8%
Total Nursing Home Patients Treated	83,676	73,081	-14.5%	71,026	-2.9%	-17.8%
VAMC Nursing Home Patients Treated	27,220	26,561	-2.5%	27,067	1.9%	-0.6%
Community Nursing Home Patients Treated	42,232	32,209	-31.1%	28,851	-11.6%	-46.4%
State Home Nursing Home Patients Treated	14,224	14,311	0.6%	15,108	5.3%	5.9%
Total Domiciliary Care	24,018	24,825	3.3%	25,670	3.2%	6.3%
VAMC Domiciliary Patients Treated	16,607	17,822	6.8%	18,895	5.7%	12.1%
State Home Domiciliary Patients Treated	7,411	7,003	-5.8%	6,775	-3.9%	-10.0%
Total Inpatients Treated	1,224,375	1,151,848	-6.3%	1,113,126	-3.5%	-10.0%
VA Staff Outpatient Visits	21,473,403	21,013,926	-2.2%	21,396,334	1.8%	-0.4%

Source: Summary of Medical Programs: FYs 1988, 1989, 1990
Department of Veterans Affairs

The pressure on nursing home care—a discretionary program—is apparent in the community segment of VA's nursing home program. The reductions in the community segment have not been accommodated in the other components of the nursing home program. The single area that has increased workload is the domiciliary program.

Table 19 clearly demonstrates a diminishing workload in the face of the aging veteran population's growing need for all types of services. We expect the erosion to continue in FY 1991 since appropriations again fall short of current services budget requirements.

ENTITLEMENT CLARIFICATION

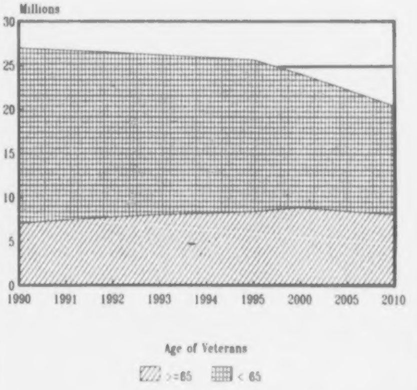
The Independent Budget authors believe that professional ethics and a commitment to delivering quality medical care dictates that health care providers are responsible for the *complete care* of their patients, and must be allowed to deliver that care according to the principles of good medical management or be relieved of the responsibility altogether. Further, all obfuscation regarding entitlement should be eliminated, health care needs should be accurately determined, and resources should be provided to meet those needs.

MEETING VETERANS' HEALTH CARE NEEDS

MEETING PROGRAM AND WORKLOAD GOALS

The VSOs have constructed the Independent Budget on the premise that strategy should drive operations. The primary mission of the Veterans Health Services and Research Administration (VHSRA) is to provide high quality health care to entitled veterans. Adequate resources should be allocated to achieve that objective. Past Independent Budgets have pursued that premise, relying on a set of strategic principles for budget formulation. Although our recommended programs and budgets have not been entirely implemented, we still consider the recommendations sound. We also maintain that, had the VSOs' recommended funding targets been achieved, the current VA health care crisis might have been averted.

CHART 2
Veteran Population 1990-2010



Source: Dept. of Veterans Affairs

The VSOs have reassessed their strategy for the VA health care system, and have reaffirmed that changes in the system are essential. Selected system changes that are in veterans' best interest can take place without cost or with minimal cost. For example, activating a Geriatric Evaluation and Management (GEM) program in each medical center would save significant resources by enabling timely, comprehensive assessment of elderly patients' medical care requirements. These GEM programs are needed to efficiently accommodate older veterans' rapidly increasing use of the system.

The apparent lack of discipline in the management of the health care system indicates a need for stronger central control. VA should not allow program or activity expansion under any circumstances without central approval in accord with a systemwide operating and strategic plan. VA should review all programs that were implemented as a result of the competitive incentives built into the now-abandoned Resource Allocation Model (RAM). In addition, VA should review and reaffirm every medical center's missions and workload targets, monitor their programs and workload levels, eliminate duplicate services in proximate sites, and distribute resources to meet established workload targets. VA must take drastic action to address the potentially devastating budget problems that its health care system now faces.

To meet veterans' needs more efficiently, VA should shift current resources as needed to achieve recommended program and workload targets. VHSRA should set realistic goals and objectives for the next five years, and establish a centrally controlled mechanism for achieving those objectives. Sound planning today will strengthen tomorrow's VA health care system.

MEETING THE NEEDS OF AGING VETERANS

Beginning in the 1980s, most veterans of the World War II and Korean War eras—the largest groups of veterans—turned 65. In 1980, there were three million veterans age 65 or older and, as Chart 2 shows, in 1990 there were seven million. By the mid-1990s, one-third of all veterans will be older than 65, and by the year 2000, almost nine million veterans will have reached this age. After 2000, the number of veterans older than 65 will decrease.

As people age—particularly as they age beyond 65—they require progressively more health care, and their need for long-term care grows even more rapidly than their need for acute care. The statistics on veterans' actual use of VA care underscore the point. As Chart 3 shows, veterans ages 65 to 74 use VA hospital care twice as often as those younger than 55. Those older than 75 use this care 75 percent more frequently than those in the 55-64 age group.

Although this increased use of VA inpatient hospital care with advancing age is dramatic, it is small compared to the increased use of nursing home care. Men ages 85 and older use VA nursing home care almost 30 times as often as men ages 55 to 64.

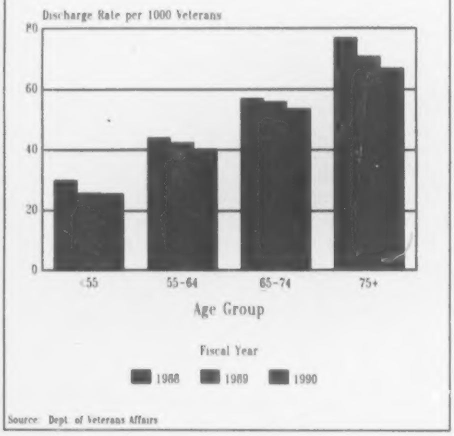
The necessity of meeting aging veterans' rapidly growing and changing needs is fundamental to this Independent Budget's Medical Care appropriation recommendations.

PROTECTING AFFILIATED TEACHING PROGRAMS

Since 1947, affiliations between VA hospitals and the nation's medical schools have been the chief source of physician staff recruitment and retention, and a major factor in the assurance of quality medical care. The private medical sector also benefits from this partnership; more than half of all practicing physicians received training in the VA health care system, even though affiliated VA hospitals represent only 10 percent of all U.S. teaching hospitals.

Because few understand what exactly this time-tested affiliation program involves, this year's Independent Budget contains Appendix C, a copy of the original memorandum of understanding upon which this partnership was, and still is, based. It was the result of Public Law 79-293 (passed by what President Truman later immortalized as "that do-nothing 79th Congress").

CHART 3
VA Hospital Discharge Rates
FY 1988-1990



Source: Dept. of Veterans Affairs

These affiliations have enabled VA medical research laboratories to contribute much to the body of medical knowledge. Extensive sharing of resources—including diagnostic and therapeutic equipment—between VAMCs and their academic affiliates existed long before "sharing" became a popular cost-containment "buzz-word." Today, the nation's medical schools provide several hundred million dollars to supplement the salaries of VA-employed physicians. Without these supplements, VA physicians' incomes would not approach parity with those of their faculty colleagues.

Over the years, affiliations have expanded to include all schools of dentistry and many schools of nursing and allied health sciences. Today, these VA hospital educational commitments constitute the nation's single largest health manpower production resource, accommodating more than 100,000 graduate and undergraduate students in the full spectrum of specialty training. This is one of VA's four Congressionally-mandated missions, specified to address the needs of the nation.

Academia values VA facilities as a teaching base for several reasons. First, VA facilities attract faculty to their concentration of teaching programs, research funding and laboratory space. The patient mix is conducive to teaching. Veteran patients' complicated health care needs require specialty services and provide training opportunities not available elsewhere. Generally, veterans' illnesses are more severe than those of non-veterans. More than 40 percent of VA patients have a psychiatric or substance abuse disorder, and veterans average five diagnoses upon admission.

Unlike private hospitals, more than 70 percent of VAMCs have long-term care components and have been in the vanguard of developing residencies in geriatrics. VA is credited with influencing the recognition of geriatrics as a subspecialty and today VA is pioneering fellowships in ambulatory care.

Conversely, protracted underfunding of VHSRA budgets and consequent staff shortages, delayed equipment replacement, and restricted admissions of patients with medical problems of special teaching value have caused demonstrable compromise in the affiliated hospitals' value as an educational setting. With shortages of support, personnel, residents and interns frequently have to assume inappropriate clerical duties, retrieve medical records, transport patients and act as laboratory technicians. The deans of the affiliated schools have voiced their concerns about this erosion in testimony before Congressional committees.

VA PLANNING FOR THE HEALTH CARE SYSTEM

There is a recognition within VHSRA that its operations planning programs have been ineffective, mismanaged and misused. The VSOs do not completely understand VA's recent restructuring of its medical system planning process, but we applaud steps VHSRA is taking to affirm medical center missions, establish workload targets, and distribute resources to meet those targets. Such steps will hopefully make resource distribution more logical and lead to utilization patterns that are consistent with mission assignment.

A major challenge rests in the need to develop a strategic planning process that is based on an assessment of the role of VA in the national health care system. An awareness of alternative futures and a plan to meet the health care needs of tomorrow's veterans are essential components of VA strategy. Although VA made attempts in this direction in 1990, the scenarios developed were unrealistic, unfocused, and failed to address the realities of the emerging health care environment. The mission of the VA health care system for the years beyond 2000 must be defined as the first step toward an organization that will be effective in the twenty-first century.

In the absence of a sound strategy for the future, VA will become a residual system defined by the patient type and casemix that no other part of the nation's system will care for. Such an outcome would undoubtedly lead to the dismantling of the system—a tragic loss not only for veterans but for the nation.

RESOURCE MANAGEMENT

VA must base resource allocations on the premise that the basic needs of all entitled veterans must be met. VA must not allow its resource allocation methodology to generate perverse incentives to expand specialty services while basic needs are not being met throughout the system. Any new system for allocation of funds should assure a stable, predictable resource base that allows facilities to accomplish their assigned missions and to meet their workload targets. In prior Independent Budgets, the VSOs advocated this position and took a strong stand against the Resource Allocation Model (RAM), which promoted damaging competition for available health care funds.

As we move into 1991, the opportunity exists to change the resource distribution system so that programs and funds provide equitable care for veterans. This will require strong leadership, perseverance and the equitable application of a set of basic principles. These principles are:

1. VA leadership must provide each facility with a clearly defined and stable mission for this decade. Central Office, working with the regional offices, should establish the facility missions. VA should allow additional programs or activities beyond the assigned mission only when it can be clearly demonstrated that innovative activities are consistent with overall VA strategic and operating plans.

2. A central authority should set workload targets within the mission based on an analysis of current workload that falls within the mission, and project that workload over two years. The central authority should categorize workload by resource consumption groups to assure adequate funding for each facility—especially for high-cost groupings such as high-technology surgery, AIDS treatments and end-stage renal disease. The capability to develop realistic facility workload targets readily exists in VA's Boston Development Center.

3. The resource distribution system should provide the funding necessary to accommodate current and short-term changes in workload. Short-term funding adjustments should not affect basic staffing and support functions if workload is near target levels.

4. High-cost, high-technology programs should be geographically distributed to maximize veterans' use of these services. VA should not duplicate such programs or create excess capacity for sharing or for sale in the private sector.

5. Resource distribution should be determined by veterans' needs and not redirected to provide service to non-veterans.

Movement in this direction is essential to assure optimum resource allocation to meet the VA health care system's primary objective.

MEDICAL CARE COST RECOVERY

Pressure to reduce the government's deficit spending has forced the implementation of medical care cost recovery programs over the objections of the veterans service organizations. The arguments against third-party reimbursement made the point that while collected revenues cannot be used to improve VA medical care, VA collections can be expected to result in increased insurance premiums for veterans and the companies that employ them.

The VSO's primary objection to collections is that the policy reneges on the nation's promise to provide medical care for veterans. These arguments did not prevail, and since the means test was implemented by budget reconciliation in 1985, it has been clear that the government does not intend to provide health care to veterans that have the means to provide for themselves. After years of inadequate budgets, and faced with new cuts as the government tries to control deficit spending and with no expectation for improvement, some of the costs of medical care were shifted to veterans and private insurers.

The VSO authors of the Independent Budget support Medical Care Cost Recovery with the qualifications that the program absolutely cannot be expanded to include recovery of costs for treatment of service-connected conditions and that some portion of the income from the program be deposited directly to the account of the recovering facility.

RELATIONSHIP WITH NON-FEDERAL HEALTH CARE SECTOR

Reform of the U.S. health care system is inevitable, and a greater variety of relationships between VA and the private sector is essential to VHSRA's survival as a comprehensive, quality health care system. The reform proposals that have emerged from official commissions and other prestigious and influential groups have not mentioned VA. From this, one might assume that it is intended that VA health care be subsumed by the system that evolves. Or, the authors of these proposals may expect the VA system to provide only the kinds of care that are not to be provided by other entities—for example, long-term psychiatric or substance abuse care.

The future of the VA health care system is, increasingly, the subject for speculation within the system itself. One option, apparently favored by some, is for tomorrow's VA system to look for resources beyond direct Congressional appropriation, on the presumption that federal budget shortfalls will surely continue. Those advocates see the need to "open the system" by reaching out to sell health care to patient populations other than veterans. The authors of the Independent Budget resolutely oppose the treatment of non-veterans in the VA system while care for entitled veterans is denied or delayed. This recommendation is founded on the premise that any concession to other funding mechanisms to support VA threatens the integrity of the VA health care delivery system. Opening VA health care to non-veterans holds the potential to undermine VA health care as an exclusive program devoted to veterans in recognition of their service to the nation. Ultimately, VHSRA would no longer be a veterans' health care system, but a federal industry in direct competition with the private medical sector.

> *It should first be assured that all access barriers to entitled veterans' health care are removed before one non-veteran is given entry to the VA system.*

While VSOs do endorse sharing VA specialized support services with DoD medical facilities and academic affiliates, it should first be assured that *all* constraints on entitled veterans' health care are removed before one non-veteran is given entry to the VA system.

One of VA's major challenges is to anticipate the future direction of U.S. health care and define its role in tomorrow's health care system. Although the Secretary's establishment of a commission to study the future mission of VA is a step in this direction, continuing attention to VA's place in the nation's health care industry will be necessary to monitor and react to change. Decisions regarding future missions and profile of the VA health care system should not be made lightly nor in haste. Scenario options for tomorrow's VA system should be fully debated and then carefully structured to fit in the context of whatever reformation is most certainly coming for the nation's health care industry.

RECOGNITION OF THE CONTINGENCY MISSION

The provision of back-up medical support to the Department of Defense in military contingencies is one of VHSRA's four Congressionally-mandated missions. In recent years this function has received little attention and has not been taken into account in the budget process. VA planning has been based on the assumption that there would be no more war. Meanwhile, the size of the military medical care system has been reduced to the point that it cannot be expected to provide treatment for the combat casualties that would result from a major engagement of ground forces.

New war brings active-duty military patients into VA hospitals that have not had enough staff to provide care for the veterans of past wars. Patients requiring certain medical specialties such as treatment for spinal cord injury and blind rehabilitation have no alternative sources of care since private sector hospitals do not have programs that compare in quality and scope to these VA services. VA doctors and nurses called to active duty leave VA facilities already suffering staff shortages.

There are two resource-related issues. Both center on the problem of additional costs VA may incur upon full activation of the contingency plan, if the department is not reimbursed. While the law clearly requires DoD to reimburse VA costs for caring for active-duty combatants, established reimbursement rates may not reflect VA costs. Current government reimbursement rates cover average costs of treating a broad spectrum of patient mix, but the types of cases DoD may refer to VA beds may be heavily weighted toward critical care and, thus, may be more expensive than the average.

In order to make VA beds available for active-duty patients, VA may have to exercise its authority under the contingency statute to refer many non-service-connected veterans for care in private sector community hospitals at VA expense. VA would have to absorb the additional cost of this private-sector care for veterans, which is not reimbursed by DoD.

RECOMMENDATIONS

The VSOs' recommendations fall within three general categories. Those described under the heading "Current Services" are actions the VSOs consider imperative to maintaining a baseline of service equivalent to the FY 1988 workload. Those described under "Strengthening Medical Care Programs" are specific program enhancements that will be necessary to adjust to changes in U.S. health care system economics and structure and to meet veterans' changing health care needs. The last set of recommendations, "Strengthing the Medical Care System," described under "Strengthening the Medical Care System," concerns broad management initiatives that the VSOs consider essential to maintaining the VA medical care system's integrity. The appropriation requirements specified in these recommendations are shown in Table 20 on page 82.

CURRENT SERVICES

The term "current services" is used in budget formulation to refer to the current workload or the amount of service delivered in the current year. If current services were adequate services, then a basis for a prospective budget could be derived by simply multiplying the cost of current services by a factor that accounts for inflation and adding funds to support new initiatives. Sadly, VA medical care services are not adequate and have not been for some time. That is why the current services calculation in this FY 1992 Independent Budget is based on FY 1988 workload, which in itself was inadequate compared to need. Each year since FY 1988, the funds appropriated for veterans' medical care have been insufficient to meet the demands, and VA has been forced to curtail services. Even though facility activations and equipment replacements have been postponed, VA has not had enough money to provide needed health care. As a consequence, workloads have been reduced through a variety of rationing mechanisms.

A perverse pattern has emerged. Inadequate budgets result in reduced workloads, which the Administration uses to justify even more inadequate budgets in subsequent years. Congressionally-mandated programs, pay raises, and employee benefits that were not provided for in appropriations further erode the baseline of services. Unless this vicious cycle is broken, the VA health care system will be damaged beyond recovery, and the nation will lose an essential resource that would cost billions of dollars to replace. Were it not for Congressional intervention during the past four years, the shortfall would have been $2 billion greater.

The Independent Budget is a documented record of the damage that the series of inadequate budgets since FY 1987 has inflicted on VA medical care. Aging equipment, the deteriorating physical plant, long waiting times, and low employee morale are all symptoms of an institution collapsing under the strain of a mission that is impossible without Congressional and Administration support.

The Independent Budget is committed to the principle that VA should maintain a system that can deliver first-rate health care to all entitled veterans. The Independent Budget asserts that the basis of current services must be adequate to meet veterans' needs, and that FY 1988 was the last year that budget shortfalls did not severely constrain VA workload. The VSOs will remain committed to workload targets based on FY 1988 levels, even though the difference between the Independent Budget and the Administration's budget gets larger each year. While the President's budget is generally decremental, providing less than required each year, the Independent Budget holds steady, insisting that the government provide for veterans in the Nineties at least as well as it did for veterans in the Eighties.

As this document's "Guiding Principles" section states, we are ever mindful of the continued need for federal budget restraint. This Independent Budget contains multiple suggestions for cost savings in the Medical Care account. These are summarized on page 101.

SERVICES IN APPROPRIATE SETTINGS

Because of changes in health care economics, and in response to the changing needs of VA's patients as they age, the Independent Budget has for several years recommended that VA modify its delivery patterns to take advantage of advances in medical technology. Many medical and surgical services that used to be provided in the hospital can be delivered more efficiently in an outpatient setting. Nursing homes, domiciliaries, adult day health care centers, and home-based health care most appropriately provide sustaining care, but VA still cares for many of its long-term patients in hospital "intermediate care" bedsections and provides inpatient care when outpatient services would suffice. Some of this inappropriate use of modalities of care can be attributed to eligibility rules, but competition for funds, fostered by resource allocation methods, has exacerbated the problem.

Analysis of VHSRA workloads over the past three years indicates that VA is moving in the right direction. Some of the decrease in FY 1990 inpatient services is offset by increases in outpatient workload. VA planning is allowing a larger role for non-institutional care. The VSOs' workload projections from the current services baseline take this improvement into account. A simplistic current services model would assume no change in delivery patterns, but the VSO model allows for the shift away from inpatient care. This Independent Budget's workload projections maintain the FY 1988 level of service, but anticipate and encourage shifts away from inpatient care to more appropriate and efficient delivery settings.

The VSOs' inpatient models identify certain procedures, such as cataract surgery and carpal tunnel release (an operation to correct a condition of the wrist), that the private sector typically performs as outpatient services. We have deducted the workload of these and other short-stay hospital services from the inpatient targets and added it to the outpatient targets. Most patients with very long hospital stays could probably be cared for less expensively in an extended care setting. It is not reasonable to count this inappropriate inpatient care in the current services baseline; therefore, VSO models reassign the excess workload incurred by very long-stay hospital patients to the nursing home current services baseline. The result is a set of projections for inpatient, outpatient, and nursing home workload that provides FY 1988 current services in settings that are efficient and appropriate in the Nineties and practical under current entitlement rules.

We cannot base the FY 1992 Medical Care budget on the inadequate FY 1991 appropriation; rather, we must base it on the Independent Budget's FY 1991 current services level of $12.9 billion. We arrived at this FY 1991 budget baseline by adding the following to the $12.1 billion FY 1990 appropriation:

o payroll items ($405 million).

o inflation ($210 million).

o other uncontrollable costs and adjustments including facility activations and workload changes in state homes. ($210 million).

PAYROLL AND INFLATION

Medical care is labor intensive; personnel compensation consumes approximately 60 percent of the FY 1991 Medical Care budget. If funds are not sufficient to support VA personnel costs, then VA must utilize funds from other discretionary medical care accounts. When these discretionary accounts are exhausted, workload must be reduced by turning patients away, extending the time between outpatient visits and delaying elective inpatient procedures. This is the corrosive result of repeated budget shortfalls. For several years, the VA Medical Care program has had to absorb the costs of pay raises, special pay increases and increases in Federal Employees Health Benefits. It also has had to cover the costs of inadequate budgets for new facility activations, and some of the cost of inflation. Under these conditions, equipment cannot be properly maintained and replaced, nor can more efficient and effective programs be implemented. These factors combine to cause a serious deterioration in the quality of veterans' health care. Funding that is not sufficient to completely support the Medical Care program payroll traps the system in a spiral of deterioration.

Funding that is not sufficient to completely support the Medical Care program payroll traps the system in a spiral of deterioriation.

Non-federal physicians' and nurses' pay has increased more rapidly than general inflation. Congress has recognized that VA cannot retain its staff of qualified health professionals at pay levels significantly lower than those available in the private sector, and has included $55.7 million in the FY 1991 appropriation for special pay for doctors and nurses. This is reportedly $50 million less than what is actually needed to cover the cost of legislated special pay; VA is to take the remainder from appropriations for personnel costs. Therefore, an additional $50 million is needed in the FY 1992 appropriation to meet these costs in full.

ACTIVATION OF FACILITIES

VA incurs activation costs when new construction or renovation is completed and new facilities are brought "on-line." Activations of facilities that will be completed in FY 1992 should require approximately $250 million. However, dollars allocated for previous years' activations have been inadequate. The money was not available because authors of the President's budget assumed that some projects would not be completed on time and, therefore, did not provide activation funds. OMB exaggerated this "slippage factor," and as a result, expensive facilities stood empty at tremendous investment cost to the government and of no use to veterans. Certainly slippage is a reality that must be taken into account, but overestimating this effect to justify budget cuts is perverse. Although, from OMB's point of view, it costs less to maintain an empty building than it does to support a functioning facility, the taxpayers get nothing for their money, and VA is forced to use medical care funds to support inactive facilities that cannot provide medical care.

Certain capital investment provisions for FY 1991 activations that will not be required in FY 1992 offset FY 1992 activation costs. These have been accounted for in our budget formulation. These non-recurring capital investments amount to approximately $200 million. The total request for facility activation in FY 1992, then, is $50 million.

AIDS PROGRAM REQUIREMENT

The VHSRA budget request for FY 1991 did not include a specific allocation for the treatment of AIDS. In past years the increase in workload levels from AIDS-infected patients has been either unfunded or underfunded. Since the cost of this expensive program, which provides care for severely ill patients, was not covered by specific appropriations, VA had to redirect funds from other programs into the AIDS program to treat veterans entitled to care.

The Independent Budget authors have recognized the need to offset the large expenditures required for AIDS treatment

TABLE 20
Medical Care
Components of Independent
Budget Recommended Appropriation

	(dollars in thousands)
FY 1991	
Current Services Level	$12,919,600
FY 1992	
Payroll Related Increases	
Retirement Programs	51,000
Annualization of 1991 Pay Raise	130,000
Annualization of 1991 Federal Employee Health Benefit	10,000
Pay Raise 1992	205,000
Within Grade Pay 1992	65,000
Health Benefits 1992	25,000
Variation in No. Workdays	30,000
Locality Pay	30,000
Inflation	250,000
Facility Activations	50,000
Adjustments to FY 1991 Program Base	120,000
Adjustments for Rate Changes	
State Nursing Homes	13,500
Community Nursing Homes	18,000
Miscellaneous	
Property Rental	1,000
AIDS	52,500
Special Pay to Clinical Personnel	50,000
TOTAL CURRENT SERVICES LEVEL 1992	$14,020,600
Additional Initiatives 1992	
Outpatient Workload Increase	215,000
Extended Care Program	364,000
Homeless Programs	5,000
Post-Traumatic Stress Disorder (PTSD)	7,250
Long-Term Psychiatric Care	1,000
Blind Veterans Rehabilitation	1,500
Prosthetics and Sensory Aids	4,000
Education and Training	157,000
Decentralized Hospital Computer Program	14,500
Equipment	100,000
FY 1992 RECOMMENDED APPROPRIATION	**$14,889,850**

See Appendix A For Explanatory Notes

and the deficits they have created in other services. Specific allocations will allow funding for other programs to be undisturbed by the current AIDS crisis.

Last year the Independent Budget authors recommended incrementing the FY 1990 current services level by $60 million to accommodate the needs of AIDS-infected patients. This year, the VSOs recommend an additional $52.5 million allocation to the FY 1991 current services budget. This allocation should bring current services up to a level adequate to care for the increased patient workload caused by AIDS and AIDS-related disorders.

STRENGTHENING MEDICAL CARE PROGRAMS

PROGRAM BALANCE AND FLEXIBILITY

The Independent Budget program and workload targets call for optimal use of the most efficient health care delivery modalities, which, based on expert medical opinion, should also provide the high quality care we seek for veterans. A balanced health care system provides the mix of inpatient, outpatient, nursing home and non-institutional care that matches the needs of its beneficiaries. Since health care modalities and technology are dynamic, the program mix and workload targets must be flexible. The system should be responsive to advances in medical technology and practice that make it possible to deliver certain health care services in less intrusive, more efficient settings. As veterans age, their health care needs change. VA must be able to adjust its programs to provide the kinds of services older veterans require. Relentless change on both sides of the health care equation—the steady advance of medical science and the aging population's growing demands—calls for dynamic, vigorous leadership to maintain the necessary program balance.

FOCUS ON NON-INSTITUTIONAL CARE

The shift toward non-institutional patient care in the nation's private and public health care sectors is also taking place in VA health care. In response to this changing environment, VA has expanded outpatient care and slowly begun to develop more adult day care health programs, community residential care programs, and hospital-based home care. Model respite care and hospice programs are also a part of this trend. The VSOs expect VA to hasten this adaptation since the non-institutional environment especially suits the needs of older veterans. The quality of life, the fundamental measure of the efficacy of medicine, is most enhanced in settings that support the maximum independence of the patient. Extended care should be delivered outside the hospital wherever possible, not only because non-institutional settings are more efficient, but because they can be more respectful of the patient's dignity. However, in order for VA to continue to shift more treatment away from inpatient settings, the barriers to access that stem from the inequitable entitlement rules in Title 38 must be removed.

ACHIEVING TARGETS

As in the past four Independents Budgets, this year's document identifies FY 1995 program workload targets and makes budget recommendations based on annual increments for achieving these targets. For the fifth year, the VSOs have reassessed these goals and continued their commitment to this realistic and essential strategy to meet veterans' anticipated health care needs.

Except for allowing for the expected shift from inpatient to outpatient, nursing home, and non-institutional settings within the currently defined entitlement scheme, the Independent Budget's program and workload targets are unchanged from last year. We have emphasized outpatient program expansion both because entitlement/eligibility distinctions have constrained outpatient delivery and because outpatient programs provide the most economical setting for most services required by veterans.

The veteran population has reached the age where a rapid expansion of extended care services is absolutely essential. Inpatient care in intermediate bedsections is an inefficient and inappropriate substitute for the kinds of sustaining care our older veterans need. The VSOs' recommendations in this document assume that VA will accelerate its shift toward nursing home and non-institutional care.

The FY 1995 workload distribution that is the basis of the VSOs' FY 1992 budget recommendations is detailed in Table 21. Unfortunately, the Independent Budget's FY 1990 targets were not achieved because of inadequate budgets and because VA was forced to absorb Congressionally-mandated programs and portions of payroll and related employee benefits increases. The VA system cannot meet our projected workload targets for the early 1990s unless the FY 1992 budget is substantially increased over FY 1991 appropriations.

Hold Hospital Inpatient Workload Constant

The Independent Budget staff uses a set of computerized models to estimate future VA inpatient, outpatient and nursing home workload. The inpatient model is population-driven and uses age-specific length of stay estimates derived from observed lengths of stay by Diagnosis Related Group

TABLE 21
Workload Targets
FY 1992 - 1995

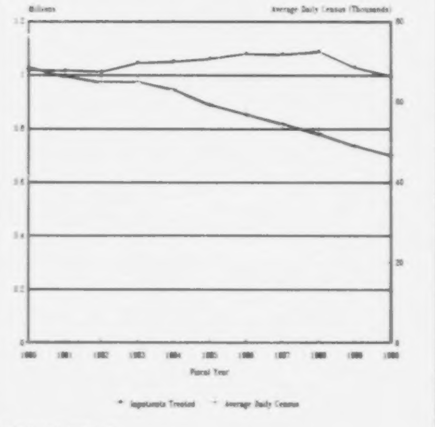
PROGRAM	1992 IB	1993 IB	1994 IB	1995 IB
VA Inpatients Treated	1,086,400	1,097,600	1,110,800	1,120,000
Contract Hospital ADC	600	600	600	600
Staff Outpatient Visits	23,887,500	23,925,000	23,962,500	24,000,000
Fee Basis Outpatient Visits	1,880,000	1,880,000	1,880,000	1,880,000
State Home Nursing ADC	11,220	11,280	11,340	11,400
VA Nursing Home ADC	16,180	17,020	17,860	18,700
Community Nursing Home ADC	14,600	15,300	16,000	16,700
VA Domiciliary ADC	7,600	7,600	7,600	7,600
Hospital Based Home Care Programs (Contract and VA)	172	172	172	172
Adult Day Health Care Programs (Contract and VA)	73	82	91	100
Geriatric Evaluation and Management Units (GEM)	172	172	172	172
Geriatric Research, Education and Clinical Centers (GRECC)	19	21	23	25
Respite Programs	172	172	172	172
Hospice Programs	172	172	172	172
Community Residential Programs	172	172	172	172

(DRG) in VA and private sector hospitals. The data are from VA's Patient Treatment File and from the National Hospital Discharge Survey. Recent statistics concerning VA hospital inpatients are shown in Chart 4.

The Independent Budget model constrains acute care bed requirement projections to a level sufficient to provide the VA casemix with the number of bed-days of care that approximates hospital stays in the private sector. The model implements the assumption that stays exceeding one hundred days in medical bedsections indicate care in a nursing home would be more appropriate. The model also makes an adjustment for very short stays—one or two days—for certain procedures that are routinely provided in outpatient settings in the private sector. These assumptions are consistent with the Independent Budget position that calls for VA to provide care in the most efficient setting.

The level of VA inpatient workload is in a state of flux. There are imponderable interactions among the variables currently influencing hospital census in the VA system. Annual budget shortfalls and progressive shifts of hospital care to non-institutional settings tend to decrease workload. The correction of current staff shortages, the AIDS crisis, the increased episodes of acute illness requiring hospitalization of increasing numbers of aged veterans, and such outreach efforts as the homeless program (HCMI) are expected to cause an increase in the number of inpatient admissions.

CHART 4
VA Inpatients Treated and Average Daily Census



Source: Dept. of Veterans Affairs

To what extent the above influences may counterbalance each other remains to be seen. For this reason, for FY 1992 budget construction purposes, we are holding constant that workload expectation. Absent these assumptions, the net results of the model show that the need for inpatient beds will hold relatively stable in FY 1992, but will slowly increase through 1995.

The model also supports the Independent Budget's recommendation for converting truly excess beds to nursing home care. When considering such conversion, care should be taken to accommodate the need for hospital beds beyond the year 1995. We also maintain that sustained low occupancy rates in some VA hospitals indicate the opportunity to integrate inpatient and extended care facilities to establish the multilayered long-term care programs described below.

Recommendation: Hold inpatient workload relatively constant in 1992.

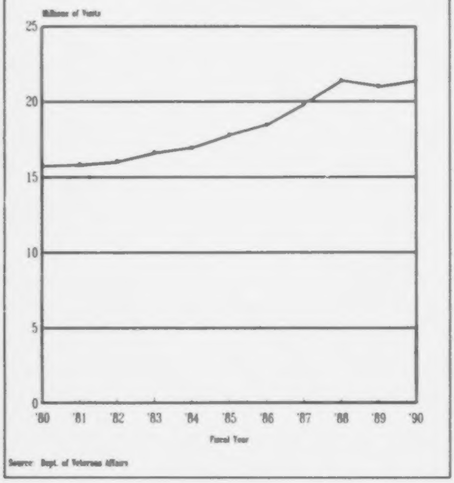
Expand Outpatient Programs

In recent years, cost considerations and advances in medical technology have caused workload to shift from inpatient to outpatient settings. Although VA has lagged the private sector in this respect, the trend toward less expensive outpatient care was evident in FY 1988 utilization data (see Charts 5 and 6). Budget constraints and the perverse effects of entitlement and eligibility legislation preclude the achievement of Independent Budget outpatient workload targets. Because of current law, some veterans who are entitled to inpatient care but not to outpatient care are admitted to hospitals for procedures that would be more appropriately performed in outpatient settings. As a result, fewer services are delivered per budget dollar, and many veterans' care is delayed or denied.

Two actions are required to correct this situation. First, Congress must eliminate the distinction between entitlement and eligibility for Category A veterans. Once entitled to health care, the veteran should receive that care in the most appropriate setting. Appropriateness should be determined by physicians and facility administrators according to principles of proper patient management. Second, the Medical Care appropriation must be adequate to provide quality care without delay. Veterans wait far too long for care, and the weeks between application and treatment incur needless suffering and costs as illnesses progress and patients' conditions degenerate.

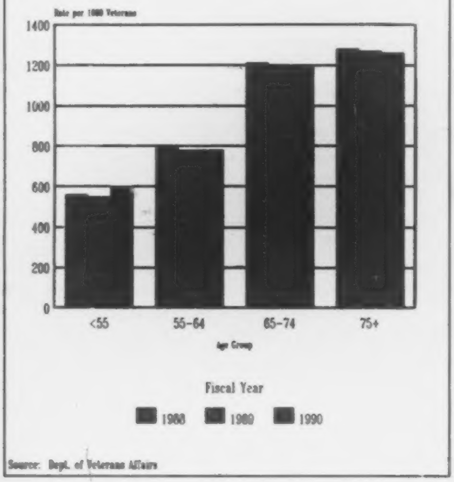
Indications are that Congress has recognized the medical, ethical, and economic arguments supporting consistent entitlement to the full spectrum of health care. Hopefully, Congress will act to alleviate the ambiguities of entitlement.

CHART 5
VA Staff Outpatient Visits



Source: Dept. of Veterans Affairs

CHART 6
VA Staff Outpatient Use Rates



Source: Dept. of Veterans Affairs

The Independent Budget's models, based on FY 1988 utilization rates and accounting for shifting some inpatient workload to outpatient clinics, indicate that VA should provide for 23,800,000 outpatient visits in FY 1992.

Recommendation: Provide outpatient care resources to accommodate 23,800,000 visits.

Cost: $215,000,000

Expand Extended Care Programs

Non-institutional forms of care maximize the patient's independence and cost less than inpatient or nursing home care. A good part of VA system's large workload in institutional long-term care programs should be shifted to extended care in non-institutional settings. If VA allocated more scarce budget dollars to home based health care, adult day health care, and community residential programs, rather than to hospitals, it could provide more veterans with better care. VA has not sufficiently expanded non-institutional programs in recent years because of insufficient funding, inadequate space, and institutional inertia. The Administration should facilitate the shift to non-institutional care, and Congress should appropriate funds necessary for programs that require additional resources for implementation. VA must move forward with initiatives that require no additional funds. Specific program workload improvements are discussed below.

Multi-Level Long-Term Care Facilities

VA should move more expeditiously to the vanguard of geriatric and long-term care. World War II veterans have reached an average age where their health calls for more sustaining care. In the last decades of life, healing takes longer, and in the last years of life, the aim of medicine must shift from curing to comforting. Our veterans are getting old now, but their average age is only about fifteen years older than that of the general population. In the 1990s, VA health care will face the crisis that society as a whole will face in the first decade of the twenty-first century. It is right that VA lead the nation in the care of the aged. Leadership in long-term care is arguably the best use of the tremendous resources that VA's nationwide system of hospitals and clinics represents. Expansion into long-term care will best assist the veteran today and prepare the country for the future.

VA is in an excellent position to develop a prototype dedicated multi-level geriatric and long-term care center. We suggest that each VA medical region select one secondary care hospital near a tertiary referral VA medical center and, through total conversion of its beds and mission, dedicate that secondary care hospital to long-term care. Each such center would offer a nursing home, a geriatric evaluation and management program, ambulatory clinics, an adult day care center, a home care team, a respite program and a hospice program. The long-term care center staff should include appropriate numbers of geriatricians, internists, physiatrists, psychologists and social workers. There should be ample facilities for functional rehabilitation, physiotherapy and occupational and recreational therapy. The center should enter into cooperative arrangements with other community-based long-term care facilities and programs.

Recommendation: Establish four multi-level long-term care facilities.

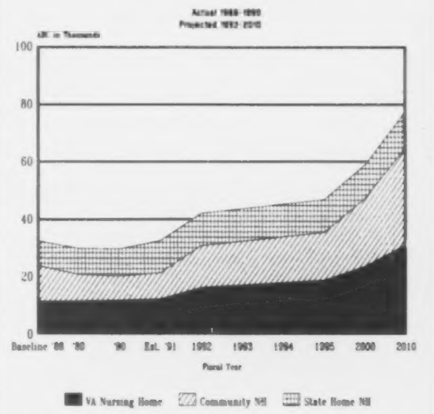
Nursing Homes

The VSOs strongly believe that expanding nursing home capacity is critical to ensuring appropriate quality care for veterans. Since 1987, the Independent Budget has called for VA to convert underutilized acute care beds to nursing home beds, but VA has made limited progress in this area. The Administration's FY 1990 budget called for the conversion of 149 beds; in FY 1991, the conversion of 79 beds was the goal. Budget constraints are partially responsible; strapped for medical care dollars, VA facility directors have been unwilling to invest in converting hospital beds to nursing home beds, even though substantial savings would result for the system.

VA hospital directors are aware that their teaching hospital affiliations and their community positions will be threatened if they are incorrectly perceived as "old soldiers homes." Our November 1990 incorrectly of VA hospitals showed that only about 20 percent of VA medical center directors would convert beds, even if funds were available for needed construction and staffing. With current inadequate funding, such sentiments doom conversion initiatives to the lowest priority.

Equally disturbing is the medical community's tendency to regard long-term care as an inferior mission. Healing medicine is more prestigious than sustaining medicine. Curing disease and returning people to productive lives is more satisfying to many health care professionals than is caring for the elderly and chronically ill. The facts, however, are inescapable—the population is aging and people are living longer. First VA, then the society as a whole, will have more elderly, infirm, and chronically ill patients to care for. VA has the opportunity and the obligation to create a nursing home program that attracts first-rate people to a career in long-term care.

CHART 7
Nursing Home Census



Source: Dept. of Veterans Affairs

Chart 7 shows that the average daily census of VA-sponsored veterans in nursing home beds declined from 32,415 in 1988 to 30,261 in 1990. This decline does not mean that the number of veterans requiring such care decreased. On the contrary, this represents a regressive shift to long-term hospital inpatient beds in response to inadequate dollars and illogical entitlement rules. Under current law, veterans are not entitled to nursing home care. Therefore, when dollars are constrained, VA is forced to reduce the nursing home census, which means that many patients are necessarily admitted to an intermediate care hospital bed or held in the hospital instead of being placed in a more appropriate long-term care setting.

The predictive model for long-term care demand that is used by both VHSRA and the VSOs is based on the 1985 National Nursing Home Survey. Analysis of this survey's results indicates that VA clients constitute approximately 20 percent of veterans in all nursing homes. This 20 percent rate was assumed to be VA's appropriate market share. Unfortunately, the VA-supported market share has declined from 19.2 percent in 1986 to 16.5 percent in 1990. Even by the most conservative reckoning, this alone has created a serious gap in meeting veterans' need for nursing home care.

In addition to VA-operated nursing homes, veterans are also accommodated in state nursing homes for which VA provides construction and operating subsidies and in community (private sector) nursing homes under VA contracts. In recent years, VA predicated planning for its nursing home placements on OMB's recommendation that state and community nursing homes provide for most of the increased demand expected in the Nineties. Thus, VA planning guidelines called for 40 percent of the census to be in community nursing homes, 30 percent to be in state homes, and 30 percent to be in VA nursing homes.

Unfortunately, VA based these guidelines on the mistaken assumption that the number of available state and community nursing home beds would increase. However, this has not materialized. Moreover, increased VA attempts to place patients in the private sector have only served to create a bidding war between VA and Medicaid for nursing home beds. Further, since VA is unable to pay what is deemed to be a fair price for a community nursing home bed, some 500 nursing homes have decided not to continue providing beds for veterans under VA sponsorship in FY 1990. States have shown only a limited willingness to accept VA's construction subsidies for state veterans nursing homes, since the states bear most of these homes' operating costs. A rapid increase in state veterans nursing homes' capacity has not been evident in recent years, and significant expansion in the near future seems doubtful. States also face difficult budget shortfalls, especially in health related programs, because the federal government is shifting more of its health care costs to state and local governments. For this reason, the Independent Budget does not expect new state nursing homes to be a significant part of the solution to the increasing need for nursing home care beds for veterans.

The Independent Budget bases nursing home workload targets on the maximum feasible expansion in the state and community nursing home program, the rapid expansion of VA nursing home programs through conversion of excess hospital beds, and new construction. The conversion goal must remain flexible because such opportunities are often limited by geographic placement problems. Moreover, nursing homes require large, contiguous blocks of space—not a few odd beds here and there—as well as recreational and social space. For this reason, we recommend that 60-bed blocks be the smallest unit of hospital beds converted to nursing home use.

For the long-term, we propose that the system add 480 VA nursing home beds annually, by completing four new 120-bed nursing homes each year and through conversions. Work on these new nursing homes must start now. Our FY 1992 Construction Programs budget proposes appropriations for four nursing homes. The construction program VA nursing home expansion requires is further described in the "Construction Programs" section below.

We recommend increasing the VA-operated nursing home census to 16,180 in 1992. To meet the overall nursing home care needs, we also recommend that the community nursing home average daily census be expanded to approximately 14,600 in 1992. In addition, we propose an increase in state veterans homes' average daily census to 11,220 in 1992.

Recommendation: Increase the VA nursing home census to 16,180, the number of veterans in community nursing homes to 14,600 ADC, and the number of veterans in state nursing homes to 11,220 ADC by the end of FY 1992.

Cost: $305,500,000

Geriatric Evaluation and Management Units (GEMS)

Geriatric evaluation and management units, through detailed assessment of older patients' medical, functional, psychological, and environmental conditions, improve treatment and discharge planning for elderly veterans who typically have multiple medical and socioeconomic problems. GEMs function in hospitals and outpatient clinics to care for patients who have secondary problems that are detected during the hospital treatment of primary illness. The objective of GEMs is to evaluate the total person. GEMs implement a holistic approach to assessing the individual's needs, for proper patient management. Assessment involves identifying disabling conditions that, if untreated, could result in greater need for institutional care, and improving treatment and management of chronic illnesses and concomitant environmental problems. Studies show that GEMs often more than pay for themselves by reducing patient institutionalization. Our proposal calls for all VA medical centers to have geriatric evaluation and management units by 1992.

Recommendation: Increase the number of geriatric evaluation and management units from 103 to 172.

Geriatric Research, Education, and Clinical Centers (GRECCs)

These centers of excellence are designed to advance geriatric and gerontological research, education, and clinical achievements. An expanded GRECC program will allow VA to maintain its clinical and educational leadership role in dealing with the problems of aging. It will foster new approaches to care that meet the complementary goals of care improvement and cost containment. The timetable with respect to GRECCs has slipped since 1982, when Congress approved increased authorization. Our goal is to have 25 GRECCs, the number authorized by statute, by 1995. Twelve GRECCs were operating at the end of FY 1990, and three more are to be opened in FY 1991. The VSOs call for VA to activate four GRECCS in FY 1992.

Recommendation: Establish geriatric research, education and clinical centers (GRECCs) in four more VA medical centers in FY 1992.

Cost: $12,000,000

Home Care, Respite, and Hospice

Hospital-based home care (HBHC) programs allow the discharge of chronically ill veterans to their own homes. These patients, who for the most part are expected to remain bedbound or housebound, can be cared for by their families at home with the support of an HBHC team from the hospital. Patients can be more comfortable in private and familiar surroundings than in hospital wards, and HBHC programs have been shown to reduce the probability of readmission to the hospital. Physicians and administrators at VA medical centers are aware of the advantages HBHC programs offer. The number of programs has increased from 30 in 1983 to an estimated that only 72 programs in 1991. VA has accomplished most of the expansion with existing resources, because no funds are specifically allocated for initiating HBHC programs. The VSOs call for the activation of HBHC programs at the remaining 100 hospitals in FY 1992.

Respite care enables an elderly or disabled veteran to be institutionalized periodically, to allow a relief period for the spouse or relatives who normally care for the patient. This relief from responsibility reduces the strain upon caregivers, and they remain willing and able to provide care for the veteran, who thus avoids permanent institutionalization. Respite care programs yield substantial gains at low cost. They make use of temporarily empty hospital beds and the staff associated with these beds. The net program cost is, therefore, little more than the staff time required for its coordination. Every VA hospital should have a program to provide respite care, but VA estimates that only 118 of 172 hospitals will have implemented these programs by the end of FY 1991. The VSOs call for the activation of respite programs at the remaining 54 hospitals in FY 1992.

Hospice programs enhance the quality of life for terminally ill veterans. Through use of an HBHC team, the program allows many patients to remain at home among familiar surroundings and family. Hospice programs also include an inpatient palliative care unit for terminal patients during periods when they cannot be cared for at home. As its name suggests, this unit's objective is relief of symptoms and patient comfort. Hospices also provide bereavement counseling to the families of dying veterans. Every month more than 25,000 World War II soldiers go to their final rest. Their honor and dignity call for the finest hospice programs and staff at every one of VA's 172 hospitals. Currently, only four programs operate nationwide. The VSOs call for the activation of hospice programs at the remaining 168 hospitals in FY 1992.

Home based care, respite care and hospice programs serve the chronically ill and their families. Since these programs are interdependent, we recommend that they be operated, managed and coordinated as a single program to meet the needs of veterans. This would reduce workload and optimize the utilization of resources. The active development of these programs will allow VA to serve more veterans within its constrained budget than would the alternative—repeated hospital admissions for chronic conditions.

Recommendation: Integrate hospital-based home care, respite care, and hospice programs and expand these programs to every VA medical center.

Cost: $33,000,000

Adult Day Health Care

The VA Adult Day Health Care program (ADHC) provides medical, rehabilitative, social, recreational, and health education services to veterans in a congregate setting during the day. ADHC services enable veterans to live at home in a supportive environment rather than be institutionalized at a significantly higher cost. ADHC serve veterans with non-disabling medical problems. Patients in intermediate stages of Alzheimer's and patients recovering from strokes are also suited to this type of treatment. The VSOs see ADHC as an effective and efficient way to reach this kind of patient.

The number of hospitals maintaining ADHC programs has increased from five in 1983 to 39 in 1990, of which, 15 hospitals operated their programs and 24 hospitals established contracts with community programs. The VSOs recommend that 34 more VA hospitals implement ADHC programs in FY 1992 to move toward the goal of ADHC programs in 100 hospitals by 1995. The VSOs further recommend that programs already existing and those to be implemented in VA hospitals in the future increase their programs' workload in order to better utilize resources associated with providing this type of care.

Recommendation: Increase the number of hospitals with adult day health care programs from 39 to 73.

Cost: $10,000,000

Community Residential Care

Community Residential Care (CRC) programs provide residential care—including room, board, and limited personal care—to veterans who do not require hospital or nursing home care but who, because of medical or psychosocial conditions, cannot live independently and have no family that can provide needed assistance or shelter. Veterans pay for community residential care, commonly with their pensions. The cost to VA involves only supervision of the program and inspection of residential care homes. CRC programs are relatively inexpensive, considering their potential for reaching members of that marginal population that have some means, but cannot manage their lives without some support. There will be 127 CRC programs in operation by the end of FY 1991. VA should create 45 in FY 1992, to move toward the goal of 172 operating CRC programs by 1992.

Recommendation: Establish community residential care programs at 45 VA medical centers.

Cost: $3,200,000

Homeless Veteran Programs

Homelessness is a national crisis which has had a devastating effect on the veteran population. Experts estimate that about one-third of the homeless are veterans—mostly Vietnam-era servicemen. The vast homeless population appears to be increasing. VA has established and funded two programs to ameliorate veteran homelessness.

The Homeless Chronically Mentally Ill (HCMI) veterans program was established by P.L. 100-6 in 1987. This law is intended to provide for aid to veterans who need psychiatric and medical care through community-provided rehabilitative services. The Domiciliary Care for Homeless Veterans (DCHV) program offers treatment, in a residential setting, of problems that have led to each individual's homelessness.

The needs for both of these programs are great. In its strategic planning projections for fiscal years 1990-1994, VA estimates that the number of homeless veterans could be as high as 250,000. Eighty-six percent of these individuals are believed to have some form of psychiatric disorder and a great many also demonstrate medical programs. VA indicates that it had contact with up to 40,000 veterans through these two programs. Between May 1987 and May 1989, 19,697 veterans were assessed by the HCMI program. About 18,000 veterans had participated in the domiciliary care program. However, veterans' needs continue to go unmet.

Homeless mentally-ill veterans characteristically exhibit a compounding array of problems. Mental illness is often accompanied by substance abuse—some facilities state that two-thirds of their homeless patients are treated for addictions to drugs or alcohol. VA has also stated that up to 45 percent of sampled veterans enrolled in HCMI programs have serious medical conditions. Veterans with Post-Traumatic Stress Disorder make up a large component of the mentally-ill population. The continued growth of the homeless population and the grave nature of its associated disorders merit attention in FY 1992 budget allocations. These funds will be used to establish new programs in metropolitan areas without programs or without enough programs. "Drop-in" centers should also be established in metropolitan areas.

Funds should be made available to programs providing the spectrum of services necessary for the treatment of the previously disenfranchised homeless veteran population. Drop-in centers serve a portion of the population that is often the most reluctant to seek help by allowing them to become familiar with a helpful, but unobtrusive care-giving setting. These centers are another means of providing care for this population and should be developed in communities with unmet needs.

Recommendation: Add five new homeless programs. Establish "drop-in" centers.

Cost: $5,000,000 added in FY 1992

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) as "a behavioral disorder that sets in after a person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone." Unlike most combat injuries, PTSD effects are often postponed, sometimes for years, before symptoms manifest. Symptoms may include behavioral problems, persistent nightmares, or violent outbursts. Problems such as substance abuse, unemployment, divorce, parenting problems, and alienation are also more likely to occur in these populations.

PTSD has become an increasingly prominent condition, particularly in Vietnam veteran populations. The National Vietnam Veterans Readjustment Study conducted by the Research Triangle Institute found that 15.2 percent of the 3.4 million Vietnam-era veterans may experience PTSD. According to this study, approximately one-half million Vietnam-era veterans need treatment for PTSD.

In 1991, there will be 44 PTSD clinical teams (PCTs) and 196 vet centers designated to provide this service. Waiting times for inpatient services can be up to two years. Currently, the 196 vet centers are responsible for providing outpatient psychological counseling for PTSD and its manifestations; and vet centers have many other mental health care responsibilities. We support the expansion of services for the treatment of PTSD. To better accommodate veteran needs, 20 new PCTs and four new inpatient units should be established in 1992. Efforts must be made to continue to target these eligible veterans and address their specific needs.

Recommendation: Add 20 new PCTs and four new inpatient units for the treatment of PTSD.

Cost: $7,250,000

Long-Term Psychiatric Care Programs

VA's long-term psychiatric hospitals need facility improvements and more psychiatric staff to adequately provide care for chronically mentally-ill veterans. As the result of FY 1991 appropriations legislation enacted by Congress last fall, funding for long-term psychiatric care was increased by $6,000,000. The authors of the Independent Budget are encouraged by this evidence of the recognition of the need for additional resources for these services; however, the FY 1991 appropriation is not enough to reverse the erosion of quality of care in VA's long-term psychiatric facilities. We believe an additional $1 million is necessary to preserve quality services and care for this program.

Recommendation: Increase funding for long-term psychiatric care by $1,000,000.

Provide Readjustment Counseling to All Veterans

All Vietnam-era veterans are eligible, by law, for readjustment counseling in vet centers. Other war veterans can receive treatment in VA hospitals but not in vet centers. Legislation introduced in the Senate in 1990 addressed these inequities of eligibility but did not pass in the 101st Congress. This bill (S. 2100) would have required VA to provide vet center readjustment counseling and follow-up mental health care to all service-connected veterans—to include veterans from all wars. We support the efforts made by the sponsors of S. 2100 in this regard and will pursue enactment of similar legislation in this session of Congress.

Recommendation: Re-introduce legislation to provide readjustment counseling to all veterans regardless of period of service.

Acquired Immune Deficiency Syndrome (AIDS)

VA estimates that its caseload represents approximately 6 percent of the nation's AIDS and AIDS Related Complex (ARC) cases. The latest projections of AIDS cases from the Center for Disease Control (CDC) indicate that there will be between 139,000 and 188,000 AIDS patients in the United States in 1992. This means that VA may see up to 11,280 patients in the year 1992 alone, including up to 3,000 new cases. There were 9,603 ARC/AIDS patients in the VA system as of September 1990. Through 1993, the cumulative VA AIDS caseload will be approximately 28,800.

DoD estimates that it will identify 1,500 to 1,700 new AIDS cases among active duty personnel annually. Approximately half of the HIV/AIDS patients who are no longer on active duty are expected to be retained in the military medical system; however, VA officials estimate that up to 1,000 new cases a year from DoD are likely to seek benefits from the VA system. Since widespread testing for HIV has precluded the entrance of infected persons into the armed forces, this number is expected to level off.

Currently, however, both prevalence and incidence of AIDS in the population are on the rise in the general and military populations, and VA must expect its total costs for treating these patients to grow proportionately.

Expensive drug therapy, lengthy inpatient stays, and frequent outpatient visits all contribute to the high cost of AIDS treatment. AZT, a drug proven to prolong the life-spans of AIDS patients, and other treatment drugs such as Pentamidine and Interferon are a large component of treatment costs. While the cost of AZT therapy has dropped from $10,000-$12,000 per patient per year in 1987 to less than $4,000 per patient per year in 1989, growing populations of AIDS patients and their increased longevity will increase VA's expenditure for this drug treatment. AZT is currently provided to approximately 50 percent of the VA patient base diagnosed with the HIV infection.

Because of advances being made in drug therapy, post-diagnosis life span for AIDS patients has increased significantly. This increased longevity translates into higher total costs for lifetime AIDS treatment per patient. The average inpatient hospital stay for an AIDS patient ranges from 27 to 44 days. In eastern regions, where the casemix includes many severely ill intravenous drug users, physicians rely more on inpatient care. The median inpatient average daily cost per AIDS patient is $764. Outpatient visits cost $158, with the average patient requiring between 33 visits per year in eastern regions and 39 visits per year in western regions.

The Independent Budget's FY 1991 current services level includes an additional $50 million for AIDS treatment. In FY 1992, we recommend that $52.5 million be added to the FY 1991 current services level, to deal with the AIDS crisis and to prevent the redirection of funds allocated to other VHSRA health care programs.

Recommendation: Add $52.5 million to the current services level for FY 1992 for AIDS treatment.

Cost: $52,500,000

Commitment to the Sustaining Treatment of the Spinal Cord Injured

Spinal cord injury (SCI) is an example of catastrophic illness dependent upon not only multi-specialty medical care, but drawing heavily on social and economic resources as well. VA, the creator of SCI treatment centers following World War II, has been in the vanguard of providing life-saving and life-sustaining support for people with spinal cord injury.

Under past resource allocation schemes, funds for SCI centers were under a "pass through" provision. This, however, did not prevent local VAMC managers from reprogramming those funds in the common effort to accommodate total facility budget shortfalls. This resulted in SCI staff shortages, delays in the provision of prosthetic and orthotic appliances, and reduced access for certain non-service-connected medically indigent SCI veterans. Now, several centers are closing "excess" beds.

Only adequate incentive pay will attract and hold SCI qualified physicians and nurses.

Thus, SCI centers are caught in that same degenerating spiral of annual budget shortfalls that is eroding the entire VA health care system. The prospect of their rejuvenation depends, in the final analysis, on dollars. Only adequate incentive pay will attract and hold SCI qualified physicians and nurses. Contracting for specialist services—including physiotherapists—is an option, but that takes even more money.

Ambulatory SCI clinics for supportive treatment of patients in satellite clinics are another option now under formal development in VACO. We strongly recommend, however, that these outpatient facilities must be organized under the chief of a regional referral SCI center. The parent-center should be responsible for training and oversight of the satellite clinics' professional staff and the monitoring of SCI patient care.

Recent restrictions on the use of beneficiary travel funding will impede the operation of this program. In-service SCI training for clinic personnel is a necessary component of successful satellite program development and that, also, requires dollars. The VA Regional Medical Education Centers (REMECs) are doing a creditable job in this early stage of program planning, but they, too, are underfunded.

Spinal Cord Injury medicine is one of those special categories of health care not likely to be covered under any "basic package" in tomorrow's nationally mandated health insurance program. It is, therefore, doubly unfortunate that erosion in the quality of VA SCI center operation has been permitted to occur. Corrective measures must be initiated at once.

Commitment to the Rehabilitation of Blind Veterans

Historically, VA has been the pioneer in the field of comprehensive residential blind rehabilitation, establishing a tradition of excellence that has served as a model worldwide. Unfortunately, this reputation is now being compromised by resource withdrawals. Staffing and space shortages have led to an increasing backlog of applicants for admission to blind rehabilitation programs.

Although more than eleven hundred blinded veterans are now on waiting lists for access to VA's inpatient programs, none of VA's eight blind rehabilitation programs, five blind rehabilitation centers or three blind rehabilitation clinics are operating at full capacity. Thirty-seven additional FTEEs for blind rehabilitation specialists are required just to support the 175-bed capacity of the eight existing programs. Realistically, an additional 100 to 120 beds are needed to provide space for the current workload.

The provision of outpatient care to eligible blinded veterans must also be expanded to meet current demand. The Visual Impairment Services Team (VIST) is an innovative and effective program pioneered by VA. Ninety-eight VAMCs currently have these teams, but only 62 of them have a full-time centralized coordinator. Experience has indicated that all teams that have more than 100 blind veterans on their rolls should have a full-time coordinator. A fully capable VIST is the most effective means of identifying veterans in need of blind rehabilitation training for independent living and for preventing medical complications. The absence of independent living skills often results in greater dependence on VA, including acute hospital admission or nursing home placement.

VA, in planning for the full impact of the aging veteran population, must consider blindness and its potential effect on the lives of veterans. A conservative estimate of the current number of blind veterans is approximately 65,000. During the next 20 years, that number will approach 80,000. The incidence of blindness increases dramatically with aging. Among the chronic disabilities of the aged, blindness is the third leading cause of the need for help in achieving basic life activities.

Blind rehabilitation is another one of those special programs in which VA has excelled beyond anything offered in the private medical sector. And blind rehabilitation is not likely to be included as a basic health benefit under any future reformation of the nation's health care system. As a consequence, VA must plan to meet this need in the veteran population.

Recommendation: Provide 37 additional FTEEs for rehabilitation of blinded veterans.

Cost: $1,500,000

Prosthetics and Sensory Aids Service (P&SAS)

Serious indictment was leveled at this service in the FY 1991 Independent Budget. During the past year, there has been measurable improvement of patient services, due primarily to a VA Central Office (VACO) directive that funds intended for prosthetics and sensory aids will not be diverted to other uses to compensate for VHSRA's budget shortfall. Other recommendations for correction of P&SAS flaws, however, are only now being addressed.

We note with satisfaction the written strategic plans recently submitted to the Chief Medical Director by the Prosthetic Service. Objectives specified in the plans include expansion of the program management and oversight staff, the establishment of additional field services and sections, commitment to educational programs for service personnel, and increased site visits. Centralized management of P&SAS resources will only be effective if appropriated funding is adequate and promptly disbursed to the field. Our November 1990 telephone survey elicited dissatisfaction with centralized servicing.

We proposed last year that an additional $4 million be provided to this service to support 50 additional FTEEs and the purchase of needed prosthetic equipment and supplies. Since these resources were not made available, even greater need exists this year. P&SAS is charged with serving the most severely disabled veterans, who typically have the highest entitlement priority. We strongly recommend the provision of these incremental resources in the FY 1992 budget.

Recommendation: Fifty FTEEs should be provided for Prosthetic and Sensory Aids Service.

Cost: $4,000,000

Beneficiary Travel

Since the system should not continue the proliferation of high-cost, high-technology programs, VA medical centers will have to refer veterans to other facilities for such programs more often. Funds must be made available to provide travel benefits to veterans who need services that are not available in their service areas. The relative economic efficiency of referring veterans to other facilities, rather than duplicating programs, will more than offset these increased travel benefit costs. Our priority is providing needed services to veterans in the most cost-effective manner.

In early FY 1991, VA began to deny hospital transportation services to veterans traveling to outpatient clinics. The VSOs immediately challenged this controversial decision and VA quickly reversed its position. Congress must vigilantly monitor funding for these important benefits. The Independent Budget authors remain committed to ensuring service accessibility to veterans through reimbursement of travel expenses.

STRENGTHENING THE MEDICAL CARE SYSTEM

The VSOs recommend that VA take steps now to make its health care system responsive to veterans' changing health care needs and to developments in the U.S. health care industry. The following proposals address many of the VA health care system's current problems and future needs.

THE UNMET NEED FOR VETERANS MEDICAL CARE: A CALL FOR A NATIONAL SURVEY AND CATCHMENT STUDY

For the past several years, progressively inadequate budgets based on arbitrary workload under-estimates have forced the Department of Veterans Affairs to ration health care. The Independent Budget has attempted to counter this trend by basing its budget proposals on a more objective concept of need. However, without information about unmet medical care need, especially for veterans classified as Category A, it will never be possible to fully estimate and plan for the basic resources necessary for the VA health care system to meet its mandated responsibilities. The obscure and confusing legal definition of veteran health care entitlement and the largely discretionary provision of VA medical care aggravate this perplexity.

We anticipate several policy changes in the VA health care system that make measurement of unmet need imperative. First of all, current assessment (and possible change) of the various VA medical centers' missions depends on accurate measures of the existing and potential user population. Secondly, knowledge of suppressed demand is critical to redefining the VA health care system in the context of the rapidly changing national health care scene. And, finally, the cost estimate of expanded Category A entitlement requires better demographic data about potential users of expanded access to VA health care. The Independent Budget has advocated a full continuum of hospital, outpatient and nursing home entitlement for this patient category. With proper management, implementing such revised entitlement could be accomplished without increasing the budget.

Since its inception, the Independent Budget has advocated a professional survey of the unmet needs of those veterans entitled to VA health care. The Government Accounting Office (GAO) study, conducted in 1989, was an inadequate attempt to address the problem. Using existing data sources and assumptions, GAO produced a result which yields insufficient information. Further, the results of the GAO study could lead to erroneous policy conclusions and legislation that could damage the VA system. The requirement remains for a comprehensive identification and analysis of the unserved veteran population.

The VSO authors of the Independent Budget will submit a legislative proposal requesting Congressional authorization and funding of a research project to collect information on potential system users. We urge Congress to direct VA to contract with an independent non-government organization, such as the National Academy of Science (NAS), to assist it in conducting, in a selected catchment area, a dual-purpose health services research program. Details of the study will be specified in a subsequent protocol submission. It will consist of a time-limited prototype effort to determine the utilization and cost of VA health care under a provisionally expanded Category A entitlement to a full comprehensive continuum of care and the simultaneous development of a complete registry of the Category A population in that geographic test area.

In addition to a cost analysis, the study would identify the current unmet veteran health care need and the potential user population and provide an opportunity for VA to demonstrate its capability of functioning in a true managed care modality. Such a study could be designed by VHSRA's HSR&D staff, executed and reported within two years. The results would most certainly be timely and of inestimable value.

Simultaneously, the study should identify unmet veteran need in specific regions of the country, to provide a basis for national and area-specific estimates. The survey, for example, must examine the Sun Belt, since many veterans are moving there. And it should also assess areas *from* which veterans are moving. It is possible, for example, that migration does not affect veterans' unmet needs because medically indigent or psychiatrically impaired veterans are unlikely to migrate.

The VSOs call on Congress to authorize and fund a VA/NAS health services research project to quantify veterans' unmet health care need and analyze the utilization and cost of a fully expanded Category A patient entitlement.

REVISE VA'S HEALTH CARE SYSTEM PLANNING

The VSOs believe that, to use available resources to full advantage, VA must first evaluate and reconfirm each medical facility's mission. National management must do this to assure regional equity of access and to be certain that each facility's mission is consistent with VA's overall strategies. We believe this is fundamental to the delivery of efficient, high-quality care. As stated previously, planning, resource allocation, and quality monitoring must be integrated. We recommend the following improvements to the operations planning process:

- The Chief Medical Director should formally specify the assigned role of each facility in the system and Central Office should define each facility's mission and workload targets. Each facility's funding should follow from its mission and assigned workload. Workload outside the assigned mission should not be funded.
- VA should centrally control the number and geographic location of high-cost programs, such as open-heart surgery, cardiac catheterization, organ transplant, radiation therapy, extracorporeal shock wave lithotripsy, and magnetic resource imaging. Such high-cost programs should be available to veterans, but only at optimal locations selected by demographic and geographic analysis of veteran populations.
- VA should establish a tracking system that requires regional directors to report each year on new program initiatives and their costs, how such initiatives meet national operations and strategic goals, the relationship to existing programs in the region, the current and projected veteran workload, and the initiatives' actual

FTEE and related costs for each of the following five years.

- VA should report each year on activations. For each project, the report should specify the number of FTEEs hired, resources used, resources deferred and the reason for such deferments, and the national operation and strategic objectives the activation meets.

The VSOs anticipated the FY 1989 funding crisis and the continuing shortfalls in FY 1990. We project that unfunded workload and the consequent erosion of quality will continue in FY 1991. It seems to the Independent Budget authors that VHSRA must also have anticipated these conditions and should have proposed better solutions long before these crises emerged. The VA health care system needs a more realistic approach to strategy and planning.

It is imperative that VA develop a sound strategy for its system. This strategy must consider alternative futures for VA in the context of the emerging health care system of the late 1990s. Such a strategy will allow VA to define its role in the context of the most likely outcome of the debate on the reform of the U.S. health care system. In the absence of such strategy, external forces will determine the VA system's role.

An effective IRM program should be adequately staffed with computer scientists, demographers, and statisticians to organize and publicize information resources.

IMPROVE INFORMATION RESOURCES MANAGEMENT

The Information Resources Management (IRM) strategy is based on the principle that information is a resource that should be managed from the highest level of an organization. Data is expensive to gather, store and maintain; to get the best return for the investment, data resources should be shared throughout the organization. Although the VSOs are satisfied that VA's IRM initiatives are based on an appreciation of these basic principles, management has been unable to exercise sufficient authority to insure adequate ADP budgets, training programs, personnel development, and integration of the various components of VA's modernization effort. The potential value of the enormous quantity of data in VA files is inestimable, but its actual value is limited by its availability and accessibility.

Apparently, intra-departmental contention involving program responsibilities and differences of opinion on design and implementation techniques have hampered the efforts to develop a comprehensive long-range plan for an integrated VA information management system. VHSRA and VBA continue to develop their systems independently without the necessary control from above to ensure maximum sharing of information resources between the two agencies. Although management has been successful in establishing department-wide standards for data base design, a totally integrated ADP system capable of interaction with proprietors and users across all agencies, departments, and management levels will not be achieved without persistent and aggressive leadership from the Office of the Secretary.

IRM involves more than gathering and storing data. Information resource managers are also responsible for disseminating data. Planners, operations managers, and researchers in VA and academia are constrained by lack of adequate documentation and access to the wealth of data VA has collected. An effective IRM program should be adequately staffed with computer scientists, demographers, and statisticians to organize and publicize information resources.

The authors of the Independent Budget encourage aggressive Congressional oversight of VA's Information Resource Management. IRM leadership and adequate funding to continue the development of VHSRA's Decentralized Hospital Computer Program is absolutely necessary. Both the National Cemetery System, which remains in critical need of ADP modernization, and the Veterans Benefits Administration must also function under IRM's clear leadership in order for VA to achieve successful ADP integration and modernization.

EVALUATE THE QUALITY OF VA CARE

This time of national emphasis on containing health care costs and evaluating the effectiveness and value of medical services has been dubbed the "Era of Assessment and Accountability." Today's literature on industrial leadership and management is replete with exhortations to focus on quality and continual improvement as the *sine qua non* for improved competitiveness, increased market share, effectiveness, efficiency, cost containment, customer satisfaction, survival, or simply because it is the "right thing to do." Similarly, any health care professional would have to agree that high quality health care systems and processes are those that meet patients' needs and desires, focus on the right tasks and consistently operate as intended.

Health care evaluation methodology is in a period of transition. This is especially true for VHSRA. Over the past year, and prior to the arrival its new leadership, extramural quality assessment of VA medical care had all but ceased. Both MEDIPRO and SERP (external peer review) activity languished. VA Central Office (VACO) had announced its intention to embrace the American Hospital Association's Quality Measurement and Management Project (QMMP), but failed to do so. VA started to collaborate with the Institute of Medicine to develop clinical indicators for measuring treatment outcomes, but no practical plans have resulted.

With the recent appointment of an associate chief medical director for quality management, VHSRA program planning for quality assessment is underway with renewed vigor. VA has announced a pending peer review contract with an outside agency to replace the current MEDIPRO program. A similar approach, called the Civilian External Peer Review Program (CEPRP), has served the military medical facilities very well. With the Administration's guidance, VHSRA will also implement the Total Quality Management (TQM) program. Such diverse health care systems as the Hospital Corporation of America, the Harvard Community Health Plan and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are also introducing TQM.

Opponents of TQM have argued that such quality improvement concepts as TQM are a shift away from traditional quality assurance approaches that seek to identify and deal with outliers as indices of quality lapses. They are concerned that the TQM approach might discourage the development of outcome evaluation models.

Proponents argue that TQM emphasizes improving entire systems in which providers deliver health care, in the belief that system failures cause most quality problems. Some advocates promote TQM with an almost evangelical fervor, insisting that it is a culture which must permeate into every area of the hospital. The president of JCAHO insists that the current focus on quality improvement does not equate to abandoning clinical indicator development. The Joint Commission is continuing to develop the latter models although it is a time consuming and expensive undertaking.

Interestingly, a November 1990 JCAHO report notes that "some hospitals are having trouble keeping pace with upgrades in commission standards. These hospitals are on a 'collision course' with rising public expectations on quality at a time when resources are constrained." A closer paraphrase to our contention that budget shortfalls damage the quality of VA medical care would be difficult to find.

We must point out that VHSRA lacks the resources to pursue this mandated focus on quality assurance. We commend VHSRA for its positive steps. The Administration and Congress must, however, realize and support the need for sizeable resources to maintain data bases and professional staff for this effort. It will require a much more sophisticated and effective automated data processing network and an overall budget commensurate with the true cost of modern quality control programs.

CLARIFY ENTITLEMENT TO VA HEALTH CARE SERVICES

For the past three years, the VSO Independent Budget authors have expressed the concern that complex and obfuscating entitlement/eligibility criteria confuse consumers and VA health care providers. VA has long professed that its health care system is unique in that it provides a comprehensive continuum of care. The claim is true only for some veterans under some circumstances. We have endorsed the principle that professional ethics and a commitment to delivering quality medical care dictate that any health care provider should be responsible for the complete care of a patient, or be relieved of that responsibility altogether.

Accordingly, we have proposed that Congress grant all Category A veteran patients clear entitlement to all types and levels of care provided in the VA system. Our proposal is timely because VA has found it necessary, in these recent years of budget shortfalls, to deny access to non-service-connected medically indigent Category A veterans, even when ambulatory care would "obviate the need" for hospitalization. VA has also had to resort to drastic constraints on nursing home admissions regardless of applicants' eligibilities or needs.

VA health care entitlement for all Category A veterans should be extended to include the full comprehensive continuity of health services, specifically, hospital care, ambulatory care, hospital based home care, nursing home care and other levels of long-term care.

ENSURE APPROPRIATION SUPPORT OF ALL MEDICAL ENTITLEMENTS

There currently exists an ironic inconsistency regarding dedicated Congressional funding appropriations for various veterans' benefit programs where entitlement is assured. In the matter of compensatory service disability, entitlement to that compensation is firmly established in law and appropriations for same are, and have been treated as, essentially inviolable.

Section 310 of Title 38, U.S.C, clearly delineates an entitlement to compensation for service-connected wounds, disease or injury and announces an intent to pay that compensation as follows: "...The United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation...". Yet, mandated health care established by the Veterans Health Care Amendments of 1986 enjoys no such guaranteed financial underpinning.

We, therefore, call upon Congress to correct this inequity and to express in law an obligation to pay for such VA health care it has mandated. And if Congress accepts the strategic tenet that Category A veterans be entitled to the full continuum of health care, then as that becomes reality in law, an expressed commitment to fully fund such care should be part of the authorizing legislation.

IMPROVE THE MEDICAL CARE CONSTRUCTION PROGRAM

In the past decade, many studies have documented the shortcomings of VA's construction program. Although the causes are well understood and past editions of this Independent Budget have made specific recommendations for improvements, the problems persist. They include:

- o Excessive time to complete construction projects, resulting in facilities that are inadequate from the time they are activated.
- o Irrational selection of construction projects for funding and development. VA does not address its most urgent needs first, and appears to have no systematic approach to addressing long-term problems.
- o Absence of an internal evaluation and improvement mechanism, to resolve systemic problems in the construction process.

We call for VA to keep foremost among its criteria for locating, designing and constructing new VA facilities consistency with its responsibility to deliver quality health care to veterans. VA must define missions for each VA medical center; the mission statements will then serve as the proper starting point for planning, design and construction.

VA must inventory its capital facilities and develop a system for maintaining that inventory. This will enable VHSRA to determine needs from a current information base. The Five Year Facility Plan, the Medical District Initiated Planning Program, the Capital Facilities Studies, and the Facility Development Planning Program did not adequately address construction needs, nor did they solve the construction program's time, design, selection and internal correction problems. Therefore, a new approach is necessary—one that utilizes logical methods for setting national construction priorities.

Once VA establishes construction priorities and funds a project, a single internal entity must manage design and construction. Managers must be responsible for keeping projects on schedule, and resolve problems before they cause delay. VA's deficiency in this regard was cited in the "Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities," which Booz, Allen and Hamilton and RTKL Associates completed for VA in April 1985. The corrective actions that this report recommended are still valid.

We recognize that VA cannot solve all construction problems immediately. We believe, however, that VA can initiate improvement by taking certain actions. Specifically, VA should:

- o Establish a logical system for setting national construction priorities.
- o Designate a single VA entity to be accountable for construction projects.
- o Develop clear realistic mission statements for each medical facility before spending any funds on Facility Development Plans (FDP).
- o Develop a Capital Facilities Inventory (CFI) system that works. The system should be a networked, distributed database, to allow maintenance and updating at each VAMC and to support analysis and report generation at the national level.

HUMAN RESOURCES DEVELOPMENT

Employee Welfare And Morale

We note with satisfaction the successful establishment of VHSRA's Office of Health Care Staff Development and Retention (OHCSDR), and its rapid progress toward comprehensive recruitment and retention programs.

As a result of recommendations submitted by the OHCSDR task force, P.L. 101-366 will be implemented this fiscal year and provide for the establishment of a system of locally competitive pay rates for VAMC nurses. This year, a pilot project to assess the benefits of eliminating rotating shifts for nurses will be launched, with 798 FTEEs authorized for this purpose.

OHCSDR has contracted a private advertising agency to execute national, regional and local publicity campaigns to promote VA as a preferred employer. Advertisements promoting the theme, "The Best Care...Keeping the Promise to Those Who Served...The New Department of Veterans Affairs" have already appeared in the media. The agency has also updated an RN recruiting brochure.

OHCSDR has also announced the development of a recruitment and retention data base, and a program whereby VHSRA is paying nurse educators to serve on the faculty of VAMC affiliated nursing schools in an effort to expand the nurse labor supply.

Future OHCSDR activities promise to focus on quality work life for all employees—exactly the innovative programming VA needs. VSO expectations include professional recognition and growth opportunities, more adequate administrative support structures, and on-site child care.

Staffing Shortages

Nurses

As referenced above, OHCSDR has rightly placed priority attention on solving VA's shortage of nursing staff. Increased pay scales, scholarship support and tuition reimbursement are all very constructive initiatives.

It is difficult to obtain accurate data on the magnitude of VA's chronic nurse shortage. More than 4,000 VA hospital and nursing home beds are still closed for lack of nursing staff. Hospitals contacted in this year's telephone survey reported a range of 20 to 50 nurse position vacancies. Shortages are particularly prevalent in intensive care units, compromising operating room capability.

Even under normal staffing conditions, nurse coverage is marginal, which makes additional shortages more critical. A June 1990 publication of the Association of American Medical Colleges titled, "The Partnership: VA Hospitals and Graduate Medical Education," makes the following statement regarding comparative staffing levels: "Despite having more total beds and similar numbers of acute care beds, when compared to nonfederal teaching hospitals, VA hospitals have fewer personnel. The average VA teaching hospital has 2.9 full-time equivalent personnel per bed as compared to 4.6 in the average nonfederal teaching hospital."

This nurse shortage is not endemic to VA, but VA is reportedly the most adversely affected system. Little beyond studying the problem has been done nationally to alter the federal government's own prediction of a one-million-nurse shortfall by the year 2000. Again, the answer lies in equitable pay, good working environment, educational opportunity and nursing school recruitment. In this regard, VA, with its scholarship and tuition reimbursement programs and nursing school affiliations, contributes more than it receives.

Physicians

The physician shortage in the VA system involves certain specialties, notably anesthesiology, radiology, orthopedic surgery and psychiatry. The recently mandated reduction in residents' work week hours will aggravate these shortages. It is unfortunate that, due to an extraneous impediment in the legislative process, Congress appropriated funding for VA physicians' increased special pay, but not the authority for its expenditure—an irony that hardly contributes to good morale. We trust authority for program implementation and more realistic funding will be finalized upon convening the next session of Congress. On the other hand, the expected exodus of VA physicians has not occurred.

Physician Assistants

Physician and nurse shortages suggest that VHSRA needs to more closely examine its physician assistant (PA) utilization and to develop this resource more effectively. With more than 900 of these valuable professionals, VA is the largest employer of PAs. Many federal agency and private sector studies have shown that, when appropriately utilized, PAs can fulfill many different clinical and administrative roles. Their training allows VA the flexibility to utilize them in inpatient wards, geriatric units, home based health care clinics, and many medical and surgical specialties.

VA could pay more attention to PA recruitment and retention. We understand VA had a 20 percent PA turn-over rate last year for, among other reasons, lack of competitive pay scales and continuing education opportunities. VA-employed PAs complain that, at least in some VAMCs, due to lack of appropriate credentialing and clear criteria covering PA clinical practice, they are not utilized appropriately and efficiently.

Education and Training

Compensatory Support of Graduate Medical Education Programs

Education of health professional personnel is one of the Department of Veterans Affairs' four Congressionally-mandated missions. The magnitude of that educational activity makes VA the nation's single largest medical manpower producer. At any given time, the VA system is training more than 100,000 students, in affiliation with almost all of the country's medical schools, all schools of dentistry, and many nursing and allied health schools. Most of these graduates enter the private medical sector.

The VSO authors of the Independent Budget strongly advocate the continued integrity of these affiliations, especially with medical schools. More than 30,000 residents rotate each year through approximately 8,500 VHSRA-funded resident positions for specialty education and training. Conversely, VAMCs, especially the large tertiary acute care facilities, depend heavily on resident physicians for patient care. These affiliations have never been more important to VA than they are today. Not only do they positively influence medical care quality, but through the years they have been VA's chief source of professional personnel. Annual cuts in Medicare's direct and indirect hospital educational funding have made medical school affiliates more dependent upon VA medical and dental training programs.

Due to circumstances beyond the control of either academia or the Department of Veterans Affairs, it has become necessary to invest a significant amount of additional resources in these teaching programs. We urge Congress to cover this cost through additional appropriation.

The Accreditation Council of Graduate Medical Education (ACGME) establishes the quality standards for residents' education and care of patients. ACGME fixes criteria for all U.S. residency programs, through special requirements by specialty, and general requirements for the training institutions. To obtain residents for VA patient care, to meet national resident care quality standards, and to participate in this national system under VA's educational mission, VAMCs with resident house staffs must meet ACGME standards.

In 1989, New York State passed stringent new code requirements regulating resident working conditions in four categories: emergency room resident staffing, supervision of residents, ancillary staff support to relieve residents of non-physician chores, and resident work-hour limits. New York State VAMCs have already complied with these standards at a cost to VA of $21 million. In 1988, the ACGME began the national process of review and revision of its Special Requirements for residency accreditation for each discipline, and its General Requirements for institutional accreditation. This process is expected to be completed in 1991. As these new standards are applied, VHSRA will need to provide significant resources to meet requirements for increased supervision of residents by staff physicians, greater ancillary staff support, emergency room staffing, and, in many disciplines, limitation of the resident's work week to an average of 80 hours. VHSRA, at the risk of losing residency program accreditation, must comply with ACGME standards. VA has distributed a circular stating policies that meet the new work hour requirements. Because of each hospital's shortened working hours for resident staff (in some instances as much as a 20- to -30 percent reduction in workload per resident), VAMCs must reassign duties to other physicians and ancillary personnel. VA is reviewing resident supervision standards, and additional staff physicians will be necessary to comply. Having started implementation in 1990, VHSRA hopes to implement the new standards across the entire VA health care system by FY 1993. The Independent Budget has no means to appraise objectively the size and timing of required additional resources. Based on its experience in New York State, VHSRA has estimated the cost of this initiative to be approximately $132 million and 2,300 FTEEs in FY 1992, with a total cost of approximately $264 million and 4600 FTEEs for full implementation.

Increase in Residents/Fellowships in High Demand Specialties

We have in past years recommended medical education program enhancements largely consistent with VHSRA's own requests, and we do so again this year. VA is experiencing increased demand in certain specialized services and is requesting additional funded FTEEs for residents and fellows in ambulatory care, substance abuse, post-traumatic stress disorder and geriatrics. Additionally, associated health fellowships are proposed for nursing, physical therapy, occupational therapy, psychology, social work and audiology/ speech pathology.

These are all priority areas where, through training opportunity, VA can attract additional professional talent to VA career commitment.

Recommendation: Appropriate 160 FTEEs for residents and fellowships in high demand specialties.

Cost: $10,000,000

Career Field and Service Chief Development

VA continually needs to ensure the professional growth of its service chiefs and clinical, technical, and administrative staff, and to groom them for advancement to key positions. VHSRA career development training programs are important tools for recruiting and retaining additional personnel.

We request $10 million in FY 1992, which will provide 20,000 units of this training. This will support development of core and service-specific clinical and administrative programs, both for entry-level and incumbent professional personnel.

Recommendation: Provide support for career field and service chief development.

Cost: $10,000,000

Continuation of Tuition Reimbursement Program

P.L. 100-322 provided $5 million each year in FY 1989 and FY 1990 for tuition reimbursement. Each year, 2,500 VA employees seeking associate degrees in nursing each received $2,000. The program now supports the 2,500 student employees through the completion of their schooling, an estimated three to five years. Current recipients will totally consume funding and, therefore, the program can accommodate no new applicants.

VA has successfully retained many of the registered nurses who graduated from this program, and the very existence of the program is a positive recruitment tool. We urge continued funding for a minimum of 750 new appointees. This will require $1.5 million in funding.

Recommendation: Appropriate $1.5 million for nursing tuition reimbursement.

Grants to Health Manpower Training Institutions

The Senate previously passed legislation authorizing health manpower grants. Legislation is again being submitted to renew this program which expired in 1982. VA medical centers are currently suffering staffing shortages in many allied health professions, and the acquisition of new technology, the aging of the veteran population and new demand resulting from AIDS, substance abuse and PTSD will generate additional workload.

As we stated in last year's Independent Budget, the VSO authors support legislation to authorize appropriations for funding grants to VA-affiliated health manpower training institutions to increase their training capacity. Grants will provide time-limited funding to support these schools' faculty and equipment, and funding to VAMCs to support minor construction projects that provide additional educational space.

AIDS Related Training

VHSRA must conduct educational and training programs for health professionals that work with AIDS-infected veterans, to give them the knowledge they need to properly manage this special class of patients and to avoid the risk of contracting this fatal disease. We recommend that $3 million be designated to fund ongoing training in safe care and management of AIDS patients.

Recommendation: Appropriate $3 million for AIDS Related Training.

The total budget recommendation for all education and training programs is $157 million.

MEDICAL MALPRACTICE COSTS

Last year, the Independent Budget recommended that Congress modify the Federal Tort Claims Act (28 U.S.C. 1346 (b), 2671-2686 and 38 U.S.C. 4116) to exempt federally employed physicians and physicians practicing in VA hospitals from tort liability for medical malpractice. Such a modification could save VA millions of dollars.

Increasingly, VAMCs must contract with private physician groups to cover certain specialty services for which VA cannot recruit physicians. This is a result of VA pay scales not being competitive with the private sector's for such specialists as anesthesiologists, radiologists, orthopedic and neurosurgeons and, in some cases, psychiatrists. Contract physicians are very expensive, and much of the expense goes to pay for their medical malpractice insurance premiums.

The authors of the Independent Budget call for Congress to modify the Federal Tort Claims Act to exempt federally employed physicians and physicians practicing in VA hospitals from tort liability for medical malpractice.

BED AND STAFFING LEVELS

VA officials frequently refer to the inefficiency of the Congressionally-imposed bed and personnel "floors," or minimums. It is important to understand the history of the mandates. Congress imposed floors in the early 1980s to stem arbitrary OMB bed and personnel reductions. We believe that the fiscal climate remains the same today as in the early 1980s; certainly, the VA health care system is a target for reductions to ease the budget deficit. The four veterans service organization sponsors of this Independent Budget believe that the personnel and bed floors should remain in place, to serve the purpose for which Congress established them.

We recognize that Congress must appropriate funds to support the personnel floors, and have argued successfully for this goal. Congress has recognized this necessity, and has asked VA to identify more accurately, through budget requests, the true requirement for personnel funds. Congress is now moving toward meeting full annual costs of medical personnel increases within that fiscal year's initial appropriation.

Medical center administrators have argued that centers could be more efficient if Congress did not require them to support personnel floors. They indicate that, in many instances, they do not need the personnel level assigned. We recommend that, in these cases, VA reassign personnel to medical centers and programs that do require additional employees, or use these personnel to initiate programs such as HBHC or convert hospital beds to nursing home beds. Such systemwide personnel realignment would greatly expand health care capabilities yet contain costs.

Elsewhere in this document we have pointed out the importance of clarifying and monitoring each medical center's mission, programs and activities, and basing staff and resource distribution on each center's mission, programs and expected workload. If VA acted on these recommendations, its personnel could meet more of the projected workload demand. This process would be most effective where the user population is clearly defined. VA could then use existing information to institute an effective resource distribution and control program.

Many medical center administrators have expressed concern about "personnel sub-floors" assigned to their facilities. These sub-floors set minimum staffing levels for indirect health care personnel such as administrative or engineering staff. We recommend discontinuing these restrictive sub-floors since they limit the flexibility of the manager.

SHARING AGREEMENTS

There are approximately 2,300 VA/DoD sharing agreements currently in effect. These arrangements improve the efficiency of both agencies by utilizing excess capacity in specialized services. Veterans and active duty military personnel benefit from more convenient access to expanded services. The VSOs endorse and encourage VA/DoD sharing, to improve program balance and flexibility.

PHARMACEUTICAL UNIT DOSE PROGRAM

Unit dose pharmaceuticals are dispensed in sealed packages that contain the amount of medicine to be taken or used at one time. Patients receive only the drugs and medication they need and un-used doses can be returned to stock rather than discarded. Dispensing pharmaceuticals by unit dose avoids the waste inherent in multiple dose dispensing where several days' supply is provided, some of which may not be necessary.

In 1976, VA began to implement the unit dose pharmaceutical dispensation system in all VA hospitals, and was to complete unit dose implementation several years ago. VA now hopes to complete implementation by 1995. Where instituted, the system has enhanced patient safety, increased drug security and reduced waste. Congress has denied incremental funding and necessary additional FTEEs since 1987. In FY 1991, VA requested $4,331,000 to continue its conversion from ward stock to unit dose. Twenty-five percent of all VA hospital and nursing home beds are still waiting for the resources to acquire this state-of-the-art drug dispensing system.

Again, like last year, we do not recommend additional resources for this purpose because of the austere budget situation. We do, however, note for the record this example of continuing service regression due to underfunding. We also recommend that completion dates for installation of unit dose capability in all VA hospitals be targeted for the near future.

Recommendation: VA should accelerate implementation of pharmaceutical unit dose systems.

DECENTRALIZED HOSPITAL COMPUTER PROGRAM

The Decentralized Hospital Computer Program (DHCP) has automated several hospital system processes that have enhanced the quality of patient care, improved communication between the wards and clinical services, and increased productivity. However, progress in automation has been uneven. Twenty-one of the largest hospitals have new computing machinery than can support the demands of the multi-function, multi-user DHCP environment. Another 61 hospitals have adequate machinery, but the remaining 90 facilities are trying to run their DHCP systems on obsolete, "hand-me-down" computers that are expensive to maintain. The Independent Budget calls on VA to provide all of its medical centers with modern computers by 1995. Upgrading computers in 30 facilities each year for the next three years would be a reasonable goal.

Another problem with DHCP is the shortage of staff in many VA hospital information services sections. VA facilities typically operate their computer facilities with a fraction of the programming staff that comparable private sector installations use. The Independent Budget calls on VA to staff sections responsible for DHCP with enough skilled programmers and information systems analysts to ensure the success of this important initiative.

The DHCP holds a tremendous resource of patient data that could support the Quality Assurance (QA) programs so important to maintaining the level of VA care. Unfortunately, access to these data has been limited by the availability of integrated software. While private sector hospitals can buy off-the-shelf QA packages, VA must draw on DHCP data. This requires QA software specifically adapted for the DHCP. The only progress toward QA software for the DHCP has come from a part-time QA special interest group that has not received the recognition and support that it should, considering the potential benefits of their project. VA leadership should organize and direct the field's effort to develop QA capabilities in the DHCP system.

Recommendation: Provide 30 hospitals with appropriate computing equipment to support the DHCP and provide 100 FTEEs for programming support.

Cost: $14,500,000

EQUIPMENT BACKLOG

It is clear that the VA equipment purchase backlog has become a serious liability to the Department. Equipment kept in service beyond its normal service life costs more to maintain than to replace. Many medical centers are using outmoded equipment, which could yield inaccurate results and delay patient assessment. The equipment purchase backlog is part of the cycle of inefficiency and declining quality that has resulted from the inadequate budgets of the Eighties. Although VA used a large part of an FY 1989 supplemental appropriation to purchase equipment, equipment purchase backlog continues to increase because more machinery is reaching the end of its useful life, while medical technology, including diagnostic and treatment equipment, continues to advance. In late FY 1990, the estimated cost to replace outdated equipment with new equipment was $1.2 billion. The Independent Budget recognizes that it is not reasonable to make up this deficit in a single budget year, but insists that VA medical facilities be properly equipped by 1995. Therefore, this years' recommendations call for $100,000,000 to purchase medical and medical support equipment in FY 1992, and we expect that future years will require significant increases in this amount. The current services component of this document carries forward $300,000 for the equipment backlog.

VA is implementing a new initiative to better manage its backlog dilemma. The VSOs will analyze the full report of the Equipment Replacement Task Force when it is available. We consider managing the medical equipment tracking system efficiently to be critical to the VA medical care program's viability.

SUGGESTIONS FOR VHSRA COST SAVINGS

o VA should locate high-technology diagnostic and therapeutic programs only where they can meet workload volume standards. Where opportune, the Department should participate in sharing arrangements to ensure efficient use of this equipment.

o In the course of VAMC mission review and reassignment, VA should confine tertiary medical care to large teaching hospitals that serve as referral centers to satellite VA facilities.

o In the course of VAMC mission review, VA should eliminate any services duplicated in proximate sites.

o VA should allow additional programs or activities beyond the assigned VAMC mission only after central review and approval of proposed programs' consistency with overall VA strategic and operating plans.

o Activating a Geriatric Evaluation and Management Program in each VA medical center would save significant resources by enabling timely, comprehensive assessment of elderly patients' medical care requirements.

o VA should make every effort to shift, wherever possible and appropriate, inpatient acute care to more efficient outpatient delivery settings.

o VA should reduce acute care patient length of stay in VA hospital beds wherever possible, to come closer to private sector hospital stays. There are, however, valid reasons why VA and private community lengths of hospital stay cannot be entirely comparable.

o VA should always favor converting excess VA hospital beds to nursing home beds over constructing new nursing homes.

o Congress should correct Category A entitlement so that VA can utilize more efficient outpatient modalities of treatment. Currently, some Category A patients are hospitalized for procedures simply because ambulatory care is not authorized for them.

o VA should shift many veterans currently in long-term care institutions to less expensive sustaining care in such non-institutional programs as community residential care (CRC), hospital-based home care (HBHC) and adult day care centers (ADHC).

- All CHAMPVA health care should shift from the private medical sector into VA medical centers.

THE FUTURE

The Independent Budget's position on basic funding requirements for the VA health care system has been unequivocal and consistent over the past four years. The Administration's $1 billion dollar FY 1991 funding increase for medical care was a response to the need to keep the system operating in its current transitory form. However, this large increase in the Medical Care appropriation, although a step in the right direction, will still fall $600 million short of what is required to meet Category A veterans' health care needs in FY 1991.

As we move into the 1990s, pressure on the system from many sources will continue to build. Not the least of these forces is the federal budget crisis which will likely continue well into the decade. And, given the stringent federal budget guidelines for program growth, the VA health care system will be at a definite disadvantage in the competition for available resources.

There are several reasons for this. First, the VA medical care program is, in budget parlance, a discretionary program. Second, veterans' need for medical care is growing as large numbers of World War II and Korean War veterans become elderly.

No issue is more important to needy and disabled veterans than the assurance of comprehensive health care.

Other factors are the pressures that result from Congress shifting Medicare and Medicaid costs to users in the form of increased co-payments and from employers shifting more health insurance costs to employees. The federal government's response to Medicare cost escalation is to shift more of the financial burden to providers and to individuals—in the amount of $25 billion over the next five years. This is on top of Medicare budget reductions totaling $50 billion during the past ten years. Such action will certainly result in more individuals, including veterans, being unable to afford the increase in co-payments and, in turn, force more otherwise independent veterans into the VA health care system's fenestrated safety net. Medicare is just beginning to feel the impact of the "graying of America." Because veterans are, on average, 15 years older than the general population, they have actually increased the pressure on the VA health care system for as many years.

Many small businesses have dropped coverage completely because of rapidly escalating insurance premiums. Forty-five percent of veterans who use the VA health care system have no other health insurance, and most of those who qualify for Medicare have no supplemental insurance. When the burden on individuals increases as private sector employers shift more health care costs to employees, still more veterans will seek the VA health care system's protection.

No issue is more important to needy and disabled veterans than the assurance of comprehensive health care. The VSOs have long been keenly aware that VA policies and resources are not the sole determinants of veterans' access to medical care, and of the quality of that care. Rather, care access and quality result from decisions, usually uncoordinated, affecting diverse health care programs under federal, state and local authority. So interdependent are public and private systems that appropriate funding shortfalls in one program lead to unanticipated consequences in another. The necessary reform of our national health care system will have a long-term impact on the VA system. Concern for the more than 35 million uninsured and the 50 million underinsured Americans is growing. Every year, according to the Labor Department, one million more people lose their health insurance.

Various organizations have developed or will soon release more than two dozen different proposals for health care system reform. Organizations that have put forth such proposals to date include the American Hospital Association, the American Medical Association, the National Leadership Commission on Health Care, the Pepper Commission, the American College of Physicians, the Ford Foundation, the National Committees on Quality Health Care, Physicians for a National Health Program, and the Heritage Foundation.

Individually-authored proposed reforms include Alain Enthoven's Consumer Choice Health Plan, Uwe Reinhart's Fail Safe Health Insurance Plan, Henry Aaron's A Prescription for Health Care, the Kennedy-Waxman Basic Health Benefits for all Americans Act and Representative Pete Stark's MEDIPLAN.

Organizations developing additional proposals include the AFL-CIO, the Catholic Hospital Association, the National Governors Association, the Steelman Commission (Social Security Quadrennial Advisory Council), Secretary Sullivan's Committee (Department of Health and Human Services), and Chrysler Motors. Surely many others will address this critical issue.

In recognition of the growing consensus that the nation must soon find a way to guarantee all citizens access to quality health care at reasonable cost, the VA medical care system needs a policy position on its appropriate future roles. VA should design its policy in the context of the U.S. health care system's likely restructuring by the year 2000. All proposals for health care system reform should take into account VA's currently mandated health care delivery and financing missions.

Within the milieu of proposals there exist several typical scenarios for the U.S. health care industry. We can characterize these scenarios as follows:

1. ***Continuing deterioration*** of the existing U.S. health care system with more uninsured and underinsured individuals; increasing Medicare co-payments; decreasing Medicare reimbursements to providers, with attempts to shift the burden of caring for the underinsured and uninsured to the states under the Medicaid program; and employers shifting more health insurance costs to employees. Contributing to this deterioration are the many health insurance organizations who avoid risks by medical underwriting to increase profits, thus defeating the very purpose of insurance.

VA should base its veterans' health care policy on objective analyses of the driving forces and management trends in the health care industry.

2. ***Incremental improvements*** to the health care system, whereby Medicaid covers more individuals; small businesses pool employment-based coverage; insurance market reforms reduce or eliminate risk underwriting, more affordable long-term care insurance becomes available and competition among providers and insurers is promoted.

3. ***Multiple state initiatives*** that address the problems created by lack of access to health care, with each state providing a different set of benefits and access improvements that include: high risk pools, small business incentives, mandated insurance coverage for employees, and single payor systems. Such initiatives would target different populations, such as small businesses, individuals and families below 100 percent of federal poverty level, and those not eligible for any other federal health program.

4. ***Federally-mandated*** universal access to health care, characterized by: mandated employer-based health insurance for all employees and dependents, covering acute care, limited preventive care and limited long-term care; limited income-based employee premiums; a federal/state program to cover the elderly, disabled and medically indigent; and a "play-or-pay" employer payroll tax to cover those otherwise uninsured.

5. ***National health insurance,*** fully portable between states, that provides basic health insurance coverage for every citizen. Basic benefits could be similar to Medicare, but include preventive and long-term care. Individuals could obtain private or employment based insurance for services not covered by the basic package. A single payor system, perhaps one that prohibits balance billing, could support cost containment efforts.

Although these scenarios are discreet in this presentation, the future U.S. health care industry may have features of more than one of the alternatives. However, describing alternative futures as scenarios allows us to speculate about the future role of the VA health care system. Within each possible outcome, it is possible to explore a set of VA health care issues and to assess its potential impact. Only through such analysis can the VA medical care system position itself to play the most appropriate role in meeting veterans' health care needs.

Should a future national system exclude such benefits as long-term care, treatment for substance abuse, and mental health services, then those who cannot purchase additional coverage or pay for such services will probably not receive them. For veterans, the VA "safety net" again would come into play, and could substantially modify Medical Care program's character, compromise recruitment and retention of health professionals, and severely strain or totally destroy the academic affiliation program.

Should health care reformation be a major political issue in the 1992 presidential campaign, and should Congress conduct hearings through 1993 in order to legislate some definitive restructuring of the nation's health care system before the turn of the century, then the time for anticipating a clearly defined policy for VA's future is now. VA health care's immense resources and its service to fundamental national values make it deserving of more than arbitrary afterthought.

The VSOs appreciate that the VA Secretary's "Mission Commission" is addressing this issue, and they look forward to additional opportunities to participate in that effort.

VA should base its veterans' health care policy upon objective analyses of the driving forces and likely financing and management trends in the health care industry. It can then determine more valid options to accommodate veterans' health care, under the various possible outcomes described above, either by modifying present arrangements or within a new delivery system.

The VSOs' primary objective is to assure that the nation remains committed to providing entitled veterans, in one way or another, with high-quality, accessible health care as we move into the twenty-first century. We recognize, however, several factors that should give pause to any consideration of dismantling VA's current health care system. Replacing VA as the nation's single largest health manpower producer would in and of itself be difficult. We also should not overlook the Department's strategic role as a back-up to the Department of Defense health care system in time of national crisis or emergency, or VA/DoD peacetime sharing resource.

From a political perspective, Congress has strong incentives to preserve the VA system's integrity, including the economic benefits that accrue to the communities that share 200,000 jobs and a multi-billion dollar annual expenditure. Finally, many veterans identify strongly with VA medical facilities, whether or not they use them. A cadre of more than 80,000 veterans donate service to system patients in the largest volunteer contribution to any government program.

The VA health care system's short- and long-term imperatives are clear. It must have adequate funding for its current veteran entitlement and system configuration. At the same time, it must initiate entitlement reform, determine unmet need, and address system realignment, to ensure VA's role in the nation's future health care system.

Medical and Prosthetic Research

The VSO authors of the Independent Budget have long believed that VA research's tremendous achievements are not fully appreciated as an integral part of the nation's health care system. A viable, quality care system cannot exist without both research and education, along with the provision of care itself.

VA research's prolific yield has served veterans' health care needs and benefited all Americans. Furthermore, research is essential to VA's academic commitment to its affiliated medical schools, and a strong incentive in recruiting and retaining a high-caliber professional staff. VA's Career Development Program, which trains physicians, scientists, and medical researchers, is a national resource. Of these trainees, 37 percent have remained in VA careers, and 20 percent, in academic research.

The appropriation for Medical and Prosthetic Research supports the three categories of VA research: medical research, rehabilitation research, and health services research.

Medical Research centers on veterans' particular problems, and most VA researchers are VA clinicians. Thus, VA medical research is clinically oriented and directly concerned with VA patients' needs.

Rehabilitation Research is an example of VA research's thrust to meet veterans' special needs. It addresses functionally impaired veterans' needs and makes use of engineering, computer and other technologies to develop new devices and techniques that overcome veterans' impairments and maximize their functional abilities and independence.

Health Services Research is directed toward improving the VA health care delivery system's effectiveness and efficiency. This includes research into improved methods of delivering health care to subgroups of patients with distinctive needs and the means to collaborate with state and community health care programs.

Historically, VA research constitutes one of the Department's most distinguished chapters. The value of VA researchers' contributions to medical knowledge and extended and enhanced lives far exceeds the cost of research.

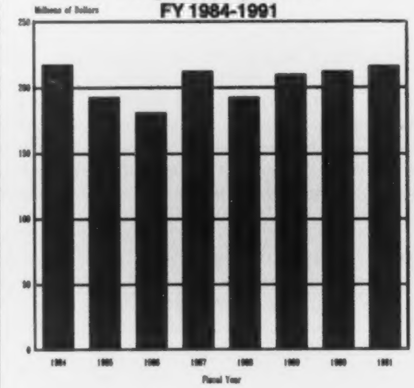
THE CHALLENGE

Health care changes rapidly. Modern medical research tools are especially costly. We note with concern that less than 2 percent of VA's annual budget has gone to research while, in other high-technology industries, the percentage is typically much higher.

VA research program decline threatens to lower staff quality and morale, and, ultimately, the effectiveness of VA graduate medical education, which sustains quality medical care. Years of absorbing pay raises, inflation, and OMB-imposed funding cuts to accommodate theoretical productivity increases have eroded the resource base for VA research, just as has been the case for medical care. That, however, is not the whole story.

For the past five years, funding has not been consistent, due to episodic, arbitrary OMB cuts. Although Congress each year has appropriated a little more than the Administration requested, resource and personnel fluctuations have been dramatic and disruptive to research programs. Most research projects require years for completion and are funded with

CHART 8
Medical and Prosthetic Research
Budget Appropriations
FY 1984-1991



Source: Dept. of Veterans Affairs

TABLE 22
Medical and Prosthetic Research Recommended Increases
(Dollars in Millions)

	FY 1990 Actual	FY 1991 Actual	FY 1991 IB Recomm. Approp.	FY 1992 IB Recomm.
Medical	$177.3	$174	$216.6	$235
Rehabilitation	21.1	25.3	28.2	28
HSR&D	9.3	15	10.2	17
Total	$207.7	$214.3	$255.0	$280.0

commitments for three years or longer. Research teams need stability. Erratic funding impairs research more than a simple examination of resource fluctuations indicates.

In an environment of budget austerity, research funding is commonly the first item decreased. That discrimination is well reflected in recent VA appropriations. In the FY 1991 budget, VA Medical Care received a $1 billion increase over a critically low FY 1990 appropriation, while Medical Research was reduced again—this time from $177 million to $174 million. As in previous years, Congress has directed DoD to transfer $20 million from its research account to VA, to support research projects applicable to military medicine. DoD has not complied with this directive. Should this supplement not be forthcoming, the VA Medical Research program will be in serious jeopardy. Ironically, both Rehabilitation Research and Health Services Research received modest increases in FY 1991, but at the expense of Medical Research.

Table 22 shows that FY 1984 VA Medical and Prosthetic Research and Development appropriation has never been matched. In constant 1984 dollars, the current $217 million appropriation has a buying power of at least $40 million less. Basing VA research current services each year on the previous year's appropriation continually builds on an eroded resource base, and does not permit recovery from the severe reductions sustained since 1985.

Paradoxically, the VA Research Office receives increasing numbers of merit-approved research proposals, yet its capacity to fund them decreases. In FY 1984, 61 percent of the 1,119 research proposals that passed merit review were funded. By FY 1988, that percentage fell to 40 percent, in FY 1989, to 36 percent and to 35 percent last year. In FY 1991, one can expect further decrease (see Table 23). Inevitably, diminishing chances for funding discourages prospective grantees from submitting proposals.

VSO STRATEGY

Out of concern for the progressive loss of VA research capability, VA Secretary Derwinski has appointed an Advisory Committee on Health Research Policy (ACHRP), consisting of nationally prominent medical research authorities, to analyze the current status of VA research structure, activity and potential and provide recommendations on how to enhance that potential. We look forward to the Committee's report as a guide for future VSO strategy.

We hope that foremost among the Committee's recommendations will be a call for realistic funding of all three components of VA research. By that we mean, at the very least, a resumption of the 1988 level of fiscal support adjusted for inflation.

SPECIFIC RECOMMENDATIONS

GENERAL

- The VSO authors recommend a sufficient FY 1992 appropriation to restore vitality to VA research, and thereafter, on a yearly basis, nothing less than realistic funding increments to keep up with inflation.
- The FY 1992 VA research funding recommendation is based on the Independent Budget's calculation of what should have been the current services level for FY 1991. To this base are added the expected 1992 uncontrollable expenses and the above referenced (DoD) $20 million. Minor incremental additions are made for special initiatives (see Table 24).
- Because for the past several years VA has come to depend on a $20 million transfer from DoD to VA research budgets as partial relief from VA budget shortfalls, we urge that Congress make proper adjustments in the two department budgets, to eliminate the need for annual transfers.
- We note, with satisfaction, that VA has flexibility to determine FTEE levels for research employment based upon funding capability. This provides VA management control of the Career Development Program, known for its high career incentive value.

MEDICAL RESEARCH

- Opportunities to pursue answers to medical problems have never been greater, especially in molecular biomedicine. The techniques of this subspecialty are

TABLE 23
Funding of Merit Review Proposals

	Merited	Funded	Percent Funded
FY 1984	1,119	683	61
FY 1985	1,064	628	59
FY 1986	1,270	670	53
FY 1987	1,228	660	54
FY 1988	1,297	581	45
FY 1989	1,322	471	36
FY 1990	1,303	450	35

particularly applicable to research in both trauma and diseases of the brain and spinal cord, the aging phenomenon, and malignancies. The VSOs recommend the following research projects be accorded special dollar increments:

Psychoses research	$1 million
Spinal Cord Regeneration research	$1 million
AIDS research	$1 million

REHABILITATION RESEARCH

- o The VSOs again recommend that VA assure more prompt and authoritative evaluation of rehabilitation research products, so that new technology can be readily released for industrial production and distribution to those in need.
- o The full potential of Functional Electronic Stimulation (FES) and robotic equipment has yet to be exploited and requires sustained support.

HEALTH SERVICES RESEARCH

- o There is a growing need for studies to identify optimal realignments of the VA health care system, cost control, and quality assessment methods. Studies are also needed to assess the impact of mandatory state level health

TABLE 24
Medical and Prosthetic Research
Components of Independent Budget
Recommended Appropriation

	(dollars in thousands)
FY 1991	
Current Services Level	$245,800
FY 1992	
Payroll Related Increases	
Retirement Programs	1,100
Annualization of 1991 Pay Raise	1,600
Annualization of 1991 Federal Employee Health Benefit	300
Pay Raise 1992	4,800
Within Grade Pay	1,200
Health Benefits 1992	800
Variation in No. Workdays	700
Inflation	3,400
Permanent Transfer from DoD	20,000
TOTAL CURRENT SERVICES LEVEL 1992	$279,700
Additional Initiatives 1992	
Medical Research Increase	3,000
FY 1992 RECOMMENDED APPROPRIATION	$282,700

See Appendix A For Explanatory Notes

Medical Administration and Miscellaneous Operating Expenses

insurance programs on the utilization of VA hospitals.

THE CHALLENGE

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation supports the VHSRA Washington, D.C. Central Office staff. These programs are essential to recruiting and retaining health care providers, and ensuring quality of veterans' medical care.

MAMOE staff levels have declined in recent years. Previous Independent Budgets have expressed concerns about staffing decreases' detrimental effects on the Central Office's ability to operate the VA health care system efficiently. Many issues demand the Central Office's immediate policy direction. Some of the most challenging issues are:

- The need for revised and effective planning.
- The need for quality control of veterans' care.
- The need for a good resource allocation model.
- The need for more effective management of VHSRA operations.

With the arrival of new and talented leadership in the VHSRA Central Office, there is fresh and promising opportunity for addressing the above issues.

The VA health care system, academia, and the private medical sector have always been interdependent. The nation's health care industry is changing profoundly. There is every indication that, in the immediate years ahead, actions by state and federal governments will significantly reorder the structure, function and financing of the pluralistic American health care system. These changes will affect the VA system significantly—but how is still unclear. Never before has it been so important for all participants and advocates of the VA health care system to work together in search of its destiny.

The VSOs remain concerned that MAMOE personnel cuts through recent years have been excessive, and have reduced VHSRA's ability to properly manage the headquarters of an operation that spends more than $12 billion dollars a year, has almost 200,000 employees, and delivers health care services at more than 200 sites. Past Independent Budgets have recommended that a private management consultant be contracted to audit the VHSRA Central Office to determine whether current austere staffing is adequate for VACO's responsibilities. With the recent reorganization, it is time for VHSRA to avail itself of authoritative appraisal.

SPECIFIC RECOMMENDATIONS

CURRENT SERVICES

MAMOE's baseline budget is the FY 1991 Independent Budget current services level of $53 million. This baseline covers payroll and inflation costs, which VA was forced to absorb in recent years.

The FY 1992 Independent Budget current services level is $55.5 million (see Table 25). An additional $2.55 million over the FY 1991 current services level is required in FY 1992 for payroll-related items—primarily, the expected 4.2 percent pay increase effective January 1, 1992—and $0.7 million is required to cover inflation in non-personnel costs. Again, these cost increases must be funded fully, to forestall further cuts in Central Office staff.

TABLE 25
Medical Administration and Miscellaneous Operating Expenses (MAMOE) Components of Independent Budget Recommended Appropriation

	(dollars in thousands)
FY 1991	
Current Services Level	$53,000
FY 1992	
Payroll Related Increases	
Retirement Programs	100
Annualization of 1991 Pay Raise	300
Annualization of 1991 Federal Employee Health Benefit	50
Pay Raise 199	900
Within Grade Pay	300
Health Benefits 1992	100
Variation in No. Workdays	100
Inflation	700
FY 1992 RECOMMENDED APPROPRIATION	$55,550

See Appendix A For Explanatory Notes

Health Professional Scholarship Program

In the FY 1991 Independent Budget we suggested that VA use its authority under P.L. 100-32 to provide medical school scholarships to recruit physicians, in addition to its scholarships for allied professional personnel. Thus far, VA has not chosen to do so. Because of its inability to recruit certain specialists, such as radiologists and anesthesiologists, VA has resorted to expensive contracts with private sector physicians.

Since VA physician shortages seem limited to certain specialties, a program similar to the military medical services' Financial Assistance Program (FAP) could be a useful part of VA's recruiting strategy. As a part of the Armed Forces Health Professional Scholarship Program, FAP allows the recruitment of civilian physicians in residency or fellowship training into the inactive Army, Navy or Air Force Reserve with a deferred active duty obligation. Since these specialists are further along in their chosen specialty training, FAP provides the military services targeted specialists much sooner than does the medical student scholarship program.

We urge Congress to provide funds for a pilot program modeled on the military's FAP to recruit specialists into VA health care. A $5 million appropriation could initiate this program for both medical students and post-graduate medical residents.

Grants for Construction of State Extended Care Facilities

This appropriation provides grants to help states acquire or construct state domiciliary and nursing homes for veterans. It also provides grants to assist expansion, remodeling, or alteration of existing facilities, including state home hospital facilities. Grants may not exceed 65 percent of the project's total cost.

As we discussed in our extended care initiative section, expansion of state homes is one important potential source of increased nursing home capacity. However, states have been reluctant to expand these homes or build new ones because they must pay most of the cost of veterans' care in these homes. In recent years, states have been less willing to participate in this program.

For FY 1992 we recommend a $70 million appropriation for these grants. We expect this will fund substantial expansion in the state home program. Based on preliminary information on the backlog of applications, states should be able to utilize the full $70 million in FY 1992.

Grants to the Republic of the Philippines

These grants help to replace and upgrade medical equipment, and rehabilitate physical plant and facilities. The Veterans' Memorial Medical Center at Manila provides care to U.S. veterans. It is now more than 30 years old, so replacement and rehabilitation are major needs. We recommend the usual annual grant of $500,000.

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CONSTRUCTION PROGRAMS
Principles And Guidelines

Independent Budget recommendations for Department of Veterans Affairs Construction Programs are based on 12 principles and guidelines:

- o Construction funding should ensure the integrity of VA's physical plant. There must be no covert downsizing of system capacity achieved by allowing the physical plant to deteriorate.
- o VA facilities must be available where veterans need them. This may require major expansions or new facility construction in areas of rapid veteran population growth. Conversely, revision of medical center mission, on a case by case basis, may be appropriate in areas of declining need.
- o VA should establish a systemwide process to set construction priorities. This process should consider all VA national and regional needs. We hold that no such single formalized process exists. It is essential that clusters of medical centers provide detailed input to national construction planning.
- o The highest construction funding priority belongs to those projects that will enable existing facilities to meet modern safety standards. Those projects include seismic protection, asbestos hazard abatement, and fire and safety deficiency corrections.
- o VA must renovate facilities to meet current privacy standards and all other statutory and accreditation criteria.
- o Primary responsibility for veterans' nursing home care rests with the federal government—not the individual states. Veterans' military service obligation was to the federal entity; we therefore hold that a converse obligation now exists.
- o The VA physical plant must be prepared to meet the growing needs of our rapidly aging veterans. Existing space and services must adapt to changing patterns of veteran care. Necessary re-configurations include large scale conversion of unused hospital beds to nursing home use, and other uses that support the medical care mission.
- o VA should improve its design and facility planning cost efficiency. Unnecessary funds spent on construction projects drain available dollars from other urgent VA programs.
- o Maintenance and construction funding should allow VA to take maximum advantage of medical technology improvements.
- o Fundamental to construction planning, VA must develop a workable inventory of all current space, and its functional and technical deficiencies.
- o The Advance Planning and Design funds must be adequate to prevent any unnecessary construction delays.
- o There should be a national cemetery in every state, with available grave space (that is, not limited to cremations) located within reasonable driving distance of major population centers. Current construction priorities should address the largest population concentrations in those states with no open cemeteries.

Construction Programs

OVERVIEW

Two appropriations fund most of VA's construction activities: 1) Major Construction, which finances projects costing $3 million or more; and 2) Minor Construction, which pays for smaller projects and the staff who plan and supervise construction activities. A third, smaller appropriation forms the Parking Garage Revolving Fund. In all three construction appropriations, most funds are dedicated to health care projects.

THE CONTINUING CHALLENGE

VA should base its construction programs on an institutionalized process that analyzes its national construction needs. However, VA has not developed a formal, analytical process to determine national priorities.

Neither has it documented each facility's needs. A rational process that accurately assesses current construction requirements in order of urgency and forecasts future needs must consider:

- o Existing structures' maintenance and repair needs, for systems such as electrical, heating and plumbing, and fixed equipment.
- o Deficiencies in the existing architectural space, mechanical systems and medical equipment that supports each medical center's current activities.
- o Projected deficiencies in the architectural space, mechanical systems and medical equipment that future medical center operations will require.

VA initiated the Facility Development Planning Program (FDPP) in FY 1987 to identify individual medical centers' current and projected facility needs. The Department maintains that Facility Development Plans (FDP) will provide an accurate systemwide inventory. However, our independent assessment of the FDP pilots indicates that these objectives have not been achieved, and the process has been costly and slow. More important, this approach will not yield accurate data in a format VA can analyze, model or update as the system and the veteran population change.

The Department originally estimated that implementing FDPP would cost $40 million (an average cost of $240,000 for each medical center) and take six months. Our investigations indicated that final costs for pilot projects far exceeded original estimates. In addition, all four pilot projects took too long to complete. Nevertheless, the Department contracted for 80 more FDP programs using a revised and untested format.

We recommend that an outside source evaluate FDPP, with a view toward developing a more simple, efficient, and cost-effective process. Such a process would more quickly develop and update basic facility data, independent of a complete facility master plan. Hopefully, this approach would profile each VA medical center's financial needs, and reduce the cost and time required to develop individual FDP programs. VA management must act immediately to prevent further irreversible expenditures based on the existing, flawed FDPP. Further, we hold that a systemwide planning process remains essential because it supports construction funding priorities.

Once VA revises the FDP Program and implements procedures that ensure accurate, useful data, VA will then have an inventory of current facility needs. Such an inventory also would help local areas prepare annual planning projections. We doubt, however, that either existing process, alone or in combination, will permit VA to establish nationwide funding priorities for construction that meet both veterans' current and future needs. VA must base construction planning on a nationwide construction strategy, and depend upon a more formal and interactive process. When developed, this strategy will help justify VA funding objectives to the Administration and Congress, and permit efficient allocation of limited construction resources.

The absence of a sound basis for establishing national construction priorities is but one of the major deficiencies in VA planning, design, and construction that several Department-commissioned studies have identified. The studies discovered several other major deficiencies:

- o Projects take too long to complete. The typical timeline for major construction, from design through completion, is ten years.
- o Design costs are often excessive, partly because of project recycling due to changing design requirements.
- o VA is unable to deal with construction problems systematically.

THE STRATEGY

Our most urgent construction program concern, then, is that VA develop an efficient facility planning and design process. Specifically, that system should enable VA to:

- Complete projects more rapidly. We believe that five years, from conception through completion, is an appropriate and attainable goal for major construction projects.
- Select projects according to strategic priorities and a national assessment of construction requirements.
- Provide projects that meet individual medical centers' present and future needs.
- Be cost-effective in planning, design, construction, and administration.
- Identify problems quickly, before they become more severe, by monitoring departmental performance in areas such as quality, timeliness, and cost.

To begin to meet these long-term goals, the Department should immediately review FDPP's adequacy. An effective FDPP will establish the foundations for Construction Programs budgets that meet veterans' true needs.

Neither we nor VA know VA's actual construction needs. However, based on our assessment of current nationwide requirements, as well as changing conditions, technologies, and demographics, we forecast immense construction and maintenance shortfalls. Accordingly, we recommend a total Construction Programs appropriation of $1.1 billion for FY 1992. This amount incorporates VA's FY 1992 construction needs as projected in its current Five-Year Plan.

Our Construction Programs proposal includes a much larger sum for Minor Construction than previous years' budgets, because of the existing plant's rapidly accelerating deterioration. We also propose a significant increase in Major Construction. We note that VA currently contracts for only two hospital replacements (or major renovations) each year. At this rate, VA's replacement/renovation cycle for its 172 hospitals would be 86 years. We believe that, in light of modern medicine's rapid advancements, this lengthy replacement cycle is unacceptable.

The FY 1992 Independent Budget also reflects our revised strategy for the National Cemetery System. For many years, VA has maintained that each of the ten federal regions needs only one national cemetery (with available burial space). Too often, the widows and children of veterans honored by burial in a national cemetery must travel extremely long distances. Realistically, this situation deprives many veterans of burial in a national cemetery.

The VSOs agree that the National Cemetery System must offer:

- A national cemetery with available grave space in every state. (Currently, 12 states do not have open burial space.)
- A national cemetery within reasonable driving distance of each of the nation's major veteran population centers.

The FY 1992 Independent Budget is designed to assist the National Cemetery System to begin to meet these two criteria.

SPECIFIC RECOMMENDATIONS

Our specific Construction Programs recommendations, like other FY 1992 Independent Budget program recommendations, are based upon the strategy we believe VA must follow to meet future challenges.

MAJOR CONSTRUCTION

We recommend a $700 million Major Construction appropriation for FY 1992. Our source for FY 1992 funding projections is VA's current Five-Year Plan. This plan may not meet the priorities that an in-depth analysis of national requirements might ultimately reveal. We also recognize that to achieve less in FY 1992 would be catastrophic, given the limited current replacement cycle, rapidly changing clinical requirements, and existing plants' excessive age.

Of the $700 million total, we recommend that Congress allocate $44 million for the Advance Planning Fund and the Design Fund (as shown in Table 26). These funds should permit more expeditious project planning and design. We believe that generous allocations to the Advancing Planning and Design funds could accelerate future construction. More importantly, the FY 1992 Independent Budget seeks to ensure the initiation of many projects. We believe that underfunding in this area impedes projects by constricting planning and design. Congress's strong support for planning and design will enable VA to build more of the major construction projects it needs, once the Department sets its priorities according to a rational process.

In the FY 1992 Independent Budget, we also request $34 million to construct new VA nursing homes. As we wrote last year, these funds will permit VA to construct four 120-bed nursing homes. The aging veteran population necessitates this rate of nursing home construction through the 1990s. Furthermore, we assert that this rate is necessary, even if VA complies with our minor construction nursing home bed conversion recommendations. These bed conversions are further discussed in the Minor Construction budget.

Finally, our Major Construction proposal includes $6.6 million to acquire land for national cemeteries in states that have none. The VSOs recommend that VA purchase and construct two new national cemeteries annually until the National Cemetery System meets previously stated goals.

The remaining amount (approximately $616 million) of the Major Construction appropriation should be devoted to the other Five-Year Plan's FY 1992 medical construction requirements. We hold that the plans are valid.

MINOR CONSTRUCTION

The Department of Veterans Affairs took a $15 million reduction in its Minor Construction budget in FY 1991. This has created a tremendous backlog in minor construction projects at the VA medical centers.

The FY 1992 Independent Budget recommends a $320 million appropriation for Minor Construction. The Minor Construction fund pays for smaller VA repair and update projects. As Table 26 shows, the Independent Budget's recommendation significantly exceeds the FY 1991 appropriation, to include funds for the backlog caused by the $15 million reduction in the Department's FY 1991 budget. This $15 million is added to the Independent Budget authors' allocation request for general medical care minor construction projects for FY 1992. The requested increment reflects the VSOs' growing concern about VA

TABLE 26
Construction Programs
Components of Independent Budget
Recommended Appropriation
(dollars in thousands)

		FY 1992 IB Recomm. Approp.		FY 1991 IB Recomm. Approp.	FY 1991 Actual Approp.
FY 1992 Major Construction					
Medical Care Construction		$615,300		$586,000	
Advance Planning Fund/Design Funds		44,100		42,000	
Nursing Home Construction		33,600		32,000	
Cemetery Construction		6,600		6,300	
FY 1992 Major Construction Recommended Appropriation		$699,600		$666,300	$580,000
FY 1992 Minor Construction					
Medical Care Funds General	197,000		168,000		
Conversion to Nursing Home Beds	56,000		42,000		
Total Medical Care Funds		253,000		210,000	
Regional Office		5,500		5,200	
National Cemetery Program		10,800		10,250	
Annual Increment for Nursing Home Bed Conversion		63,000		60,000	
FY 1992 Minor Construction Recommended Appropriation		$352,300		$285,450	$130,640
FY 1992 Parking Garage Revolving Fund		$25,000		$19,000	$28,900
TOTAL CONSTRUCTION PROGRAMS		$1,076,900		$970,750	$739,540

facilities' urgent updating and repair needs. Most VA facilities were constructed during the 1950s, and therefore update and repair needs are increasing rapidly. Earlier appropriations have fallen far short of addressing these needs.

Most of the recommended Minor Construction funds ($253 million) are identified for medical construction. The FY 1992 Independent Budget recommends that $56 million of this amount be used to convert unused medical center beds to nursing home care. This $56 million allocation should be sufficient to convert 2,500 beds during this fiscal year. This proposal also reflects the VSOs concern that VA did not achieve the FY 1991 Independent Budget's recommended bed conversion.

The VSO analysis of veteran nursing home needs indicates that VA must convert approximately 1,000 VA unused hospital beds to nursing home care each year for the next several years. VA medical centers have resisted undertaking such conversions (including those that VHSRA has planned). An annual provision of $20 million for these conversions would end the Department's claims that lack of construction funds has prevented such conversions. As stated earlier, the VSOs hold the federal government responsible for adequate nursing home care for the nation's aging veterans.

We have requested modest amounts within the Minor Construction appropriation to support VA regional office and existing national cemetery construction projects. The FY 1992 Independent Budget recommends $6 million and $11 million, respectively, for these purposes.

Finally, the Independent Budget recommends $63 million in Minor Construction funds for VA construction staff (primarily within the Office of Facilities). This funding should permit staffing at current levels. This proposal demonstrates the VSOs' concern that VA personnel take appropriate steps to establish national construction priorities, and improve construction and planning.

PARKING GARAGE REVOLVING FUND

The FY 1992 Independent Budget recommends a $25 million allocation to this fund, which finances VA facility parking garage construction and operation. We believe that reasonable parking access is essential to patient care. We hope that, eventually, parking garage revenues will pay for new projects. Currently, however, only a few revenue-producing projects exist, so VA needs limited new appropriations. Future funding requirements should diminish.

[redacted]

APPENDIX A
Budget Explanatory Notes
Medical Care

1. Funds required in FY 1991 to maintain the service level that existed in FY 1988.

2. Represents the increased cost of retirement programs including the Federal Employment Retirement System and Social Security.

3. The cost of the 4.1 percent pay raise implemented in January 1991. This amount covers the remaining three months of FY 1991.

4. The amount necessary to annualize the increase in health benefits costs that became effective January 1991.

5. The estimated cost of a pay raise of 4.2 percent effective January 1992.

6. The estimated cost of longevity/ performance increases for FY 1992.

7. Estimated increase in the cost of health benefits that will be effective January 1992.

8. The cost for an additional calendar day of work. (FY 1991 had 261 workdays; FY 1992 will have 262).

9. The additional cost to increment salaries for personnel in high-cost areas.

10. The estimated costs of inflation for items other than personnel.

11. Personnel, equipment and other costs related to the activation of new or remodeled facilities in FY 1992, adjusted for amounts obligated in FY 1991 for equipment and other capital purchases that will not recur in FY 1992.

12. Adjustments to the FY 1991 current services level to accommodate changes actually made by VA in achieving workload targets.

13. Adjustment for increases in state nursing home rates.

14. Adjustment for increases in community nursing home rates.

15. Estimated increased cost of property rental.

16. Amount needed to provide care for unanticipated workload increases related to AIDS.

17. Funding necessary to compensate increased pay to nurses and physicians appropriated but not authorized in legislation and to annually increment this increased pay.

18. Total of 1 thru 17.

19. Estimated costs associated with needed outpatient workload expansion.

20. Costs of essential improvement to the VA extended care programs, including expansions in nursing home workloads and increasing programs such as hospital-based home care, adult day health care, geriatric evaluation and management units, geriatric research, education and clinical centers, respite, hospice and community residential centers.

21. Funds necessary to provide care for veterans in metropolitan areas that have little or no capacity for care of the homeless population.

22. The amount necessary to expand facilities for the treatment of veterans suffering from Post-Traumatic Stress Disorder.

23. The amount necessary to improve the psychiatric capability in long-term hospitals providing this type of care.

24. The amount necessary to maintain the staffing and equipment needs of the Blind Veterans Rehabilitation program.

25. The amount necessary to assure personnel, devices and aids necessary to support the prosthetics program.

26. Additional funding requirements for education and training programs, including the additional funding requirements to augment medical personnel needed to replace resident hours lost by conforming to ACGME standards of an 80-hour work week.

27. Funds necessary for the decentralized hospital computer system implementation.

28. Additional requirement to incrementally eliminate a critical $1 billion backlog of medical equipment replacement in the VA system.

29. The Independent Budget recommended appropriation to provide for an acceptable level of service to veterans in FY 1992.

MEDICAL CARE
Components of Independent Budget
Recommended Appropriations
(dollars in thousands)

FY 1991		
Current Services Level	$12,919,600	(1)
FY 1992		
Payroll Related Increases		
Retirement Programs	51,000	(2)
Annualization of 1991 Pay Raise	130,000	(3)
Annualization of 1991 Federal Employee Health Benefits	10,000	(4)
Pay Raise 1992	205,000	(5)
Within Grade Pay 1992	65,000	(6)
Health Benefits 1992	25,000	(7)
Variation in No. Workdays	30,000	(8)
Locality Pay	30,000	(9)
Inflation	250,000	(10)
Facility Activations	50,000	(11)
Adjustments to FY 1991 Program Base	120,000	(12)
Adjustments for Rate Changes		
State Home Nursing Home	13,500	(13)
Community Nursing Home	18,000	(14)
Miscellaneous		
Property Rental	1,000	(15)
AIDS	52,500	(16)
Special Pay to Clinical Personnel	50,000	(17)
TOTAL CURRENT SERVICES LEVEL 1992	**$14,020,600**	(18)
Additional Initiatives 1992		
Outpatient Workload Increase	215,000	(19)
Extended Care Program	364,000	(20)
Homeless Programs	5,000	(21)
Post-Traumatic Stress Disorder (PTSD)	7,250	(22)
Long-term Psychiatric Care	1,000	(23)
Blind Veterans Rehabilitation	1,500	(24)
Prosthetics and Sensory Aids	4,000	(25)
Education and Training	157,000	(26)
Decentralized Hospital Computer Program	14,500	(27)
Equipment	100,000	(28)
FY 1992 RECOMMENDED APPROPRIATION	**$14,889,850**	(29)

APPENDIX A

Budget Explanatory Notes Medical and Prosthetic Research

1. Funds required in FY 1991 to maintain the same service levels as 1) 1985 in Medical Research, 2) 1988 in Rehabilitation Research and 3) 1989 in HSR&D.
2. The increased cost to VA in retirement programs, including the Federal Employment Retirement System and Social Security.
3. The amount necessary to annualize the 4.1 percent pay raise implemented in January 1991. This amount covers the remaining three months of FY 1991.
4. The amount necessary to annualize the increase in health benefits costs that became effective January 1991.
5. The estimated cost of a pay raise of 4.2 percent effective January 1992.
6. An estimate of longevity/ performance increases for FY 1992.
7. Estimated increase in health benefits that will be effective January 1992.
8. The cost for an additional calendar day of work (FY 1991 had 261 workdays; FY 1992 will have 262.)
9. The estimated cost of inflation for items other than personnel.
10. Amount to be permanently transferred to the VA account from the DoD account for research purposes.
11. Total of all of the above.
12. Funds for increases in Medical Research.
13. The amount necessary to provide a level of research funding acceptable to the VSOs.

MEDICAL AND PROSTHETIC RESEARCH
Components of Independent Budget
Recommended Appropriation
(dollars in thousands)

FY 1991		
Current Services Level	$245,800	(1)
FY 1992		
Payroll Related Increases		
Retirement Programs	1,100	(2)
Annualization of 1991 Pay Raise	1,600	(3)
Annualization of 1991 Federal Employee Health Benefits	300	(4)
Pay Raise 1992	4,800	(5)
Within Grade Pay	1,200	(6)
Health Benefits 1992	800	(7)
Variation in No. Workdays	700	(8)
Inflation	3,400	(9)
Permanent Transfer from DoD	20,000	(10)
TOTAL CURRENT SERVICES LEVEL 1992	**$279,700**	(11)
Additional Initiatives 1992		
Medical Research Increase	3,000	(12)
FY 1992 RECOMMENDED APPROPRIATION	**$282,700**	(13)

APPENDIX A
Budget Explanatory Notes
Medical Administration and Miscellaneous Operating Expenses

1. Funds required in FY 1991 to maintain the service level that existed in FY 1988.

2. The increased cost to VA in retirement programs, including the Federal Employment Retirement System and Social Security.

3. The amount necessary to annualize the 4.1 percent pay raise implemented in January 1991. This amount in covers the remaining three months of FY 1991.

4. The amount necessary to annualize the increase in health benefits costs that became effective January 1991.

5. The estimated cost of a pay raise of 4.2 percent effective January 1992.

6. An estimate of longevity/ performance increases for FY 1992.

7. Estimated increase in health benefits that will be effective January 1992.

8. The cost for an additional calendar day of work. (FY 1991 had 261 workdays; FY 1992 will have 262.)

9. The estimated cost of inflation for items other than personnel.

10. The amount necessary to provide a level of service acceptable to the VSOs.

**MEDICAL ADMINISTRATION
AND
MISCELLANEOUS OPERATING
EXPENSES (MAMOE)
Components of Independent Budget
Recommended Appropriation
(dollars in thousands)**

FY 1991		
Current Services Level	$53,000	(1)
FY 1992		
Payroll Related Increases		
Retirement Programs	100	(2)
Annualization of 1991 Pay Raise	300	(3)
Annualization of 1991 Federal Employee Health Benefits	50	(4)
Pay Raise 1992	900	(5)
Within Grade Pay	300	(6)
Health Benefits 1992	100	(7)
Variation in No. Workdays	100	(8)
Inflation	700	(9)
FY 1992 RECOMMENDED APPROPRIATIONS	**$55,550**	(10)

APPENDIX B
Entitlement and Eligibility Criteria For Department of Veterans Affairs Medical Care Benefits

There is unfortunately considerable confusion regarding, first of all, the definition of a veteran eligible for benefits under programs administered by the Department of Veterans Affairs (VA) as well as the criteria for participation in various levels of VA health care delivery. Eligibility differs for hospital care, outpatient care and long-term care. It also differs according to the veteran's status. Thus there are many practical problems in the planning and delivery of health care for veterans, VA administrators and budget officials in the executive and legislative branches. Were eligibility further clarified and rationalized, it would greatly facilitate the delivery of medical services.

It should be noted that "entitlement" references conditions where provision of care is *mandatory*. "Eligibility" refers to situations where VA *may* provide medical care, under certain conditions, including space and resource availability.

DEFINITION OF A VETERAN

A major change in the definition of a veteran took place in September 1980. Individuals entering service since that time generally must have served 24 months (the minimum service requirement), or longer, in the armed forces in order to be eligible for full veteran benefits. Exceptions to this rule are those who were discharged from the service for medical reasons, as a hardship, or at the convenience of the government. A dishonorable discharge is disqualifying.

Members of the U.S. Coast Guard are given veteran status and become eligible for VA benefits *if* they served during periods of war (during which periods the Coast Guard is assigned to the Navy).

Members of National Guard and military reserve units are not eligible for veteran benefits unless they meet the above criteria.

QUALIFICATIONS FOR ACCESS TO VA HEALTH CARE

Current laws governing eligibility for VA health care services are the product of Congressional action and compromise, reflecting the historical U.S. emphasis on service-connected disability and low income as the principle criteria entitling veterans to treatment. All veterans have been, until recently, divided into three groups (Categories A, B, and C) in determining eligibility for hospitalization in VA medical centers. However, recent changes in the law have collapsed the three categories into two—Category A and "all other" veterans.

Means Test Categories relate to the "Veterans Health Care Amendments Act of 1986" (P.L. 99-272) effective July 1, 1986. The intent of the law is to ensure that veterans with service-connected disabilities and other special groups of veterans, as well as those with low income, are provided VA medical care, albeit under differing conditions. The law established an eligibility assessment procedure (means test) based on income for determining whether a non-service-connected veteran qualified for Category A or the "all other" classification. Service-connected and exempt veterans do not undergo the income-based eligibility assessment.

Listed below are the criteria for inpatient (hospital) and outpatient care, nursing home care, beneficiary travel as well as certain other benefits.

HOSPITAL CARE

CATEGORY A:

(1) The Secretary of the Department of Veterans Affairs (VA) is required to provide hospital care to:

   (a) Veterans with service-connected disabilities;

   (b) Former prisoners of war;

   (c) Veterans exposed to certain herbicides and ionizing radiation;

   (d) Veterans disabled as a result of VA treatment or vocational rehabilitation;

   (e) Veterans of the Mexican border period, or World War I;

   (f) Non-service-connected veterans whose income does not exceed the means test cap (the cut-off is currently in the $15,000 to $20,000 range).

(2) Income for purposes of non-service-connected medical care eligibility will be determined on the same basis

used for determining eligibility for non-service-connected pension benefits. The income limits for medical care purposes are increased effective January 1 of each year by the same percentage as non-service-connected pension rates.

(3) The VA health care system treats some 1,000,000 inpatients a year. Some 93 percent are Category A.

"ALL OTHER" CATEGORY:

(1) Veterans outside the Category A "net" continue to be eligible for inpatient care as space and resources permit, but they must pay a part of the cost for inpatient, outpatient or nursing home care. Currently, the veteran is charged the lesser of the cost of care received or $592 for the first 90 days of care (or part thereof) during any 365-day period. For each succeeding 90 days of care (or part thereof) the veteran would be required to pay the lesser of the cost of hospital care received or one-half of the amount of the inpatient deductible ($296). For nursing home care for each 90 days of care, the veteran would be required to pay the lesser of the cost of furnishing care or the inpatient deductible ($592).

(2) The Secretary is authorized to recover from health insurers the reasonable costs of care furnished in Department facilities to insured veterans who have no service-connected disability and to insured service-connected veterans for the cost of treating a non-service-connected condition.

(3) The provision of law allowing veterans 65 years of age or older to receive care in VA medical facilities regardless of income was repealed by Public Law 99-272.

OUTPATIENT CARE

(1) The Secretary shall furnish on an ambulatory or outpatient basis such medical services, other than dental services, as the Secretary determines are needed to:

- (a) Any veteran for service-connected disability;
- (b) Any veteran with a service-connected disability rating 50 percent or more for any disability; and,
- (c) Any veteran disabled as a result of VA treatment or in pursuit of vocational rehabilitation.

(2) The Secretary shall furnish out-patient or ambulatory medical services reasonably necessary in preparation for or to obviate the need for hospital admissions, or as follow-up to hospital care for a period not to exceed 12 months, for any disability to:

- (a) Any veteran with a service-connected rating of 30 or 40 percent; and,
- (b) Any veteran whose annual income does not exceed the maximum annual rate of non-service-connected pension payable to a veteran in need of aid and attendance for any disability (currently $10,824 for a single veteran and $12,922 for a veteran with one dependent) for any disability.

(3) The Secretary may furnish on an ambulatory or out-patient basis medical services which the Secretary determines are needed to veterans in the following priority order:

- (a) Any veteran who has a service-connected disability rating of less than 30 percent or any veteran for a compensation or pension examination;
- (b) Former prisoners of war and veterans with eligibility based on exposure to toxic substances in Vietnam or to ionizing radiation during atmospheric detonation of a nuclear device, or who were exposed to ionizing radiation following the detonation of such devices in Japan during World War II;
- (c) Veterans of the Mexican border period or World War I whose annual income exceeds the maximum annual rate of pension; and,
- (d) Veterans in receipt of increased pension or compensation based on the need of regular aid and attendance or by reason of being permanently housebound, but whose income is below the Category A threshold.
- (e) Veterans who are eligible for hospital care, but who are not specified in paragraphs (a)-(d) above, for any disability, if reasonably necessary in preparation for, or to obviate the need for, hospital admission, or as a follow-up to hospital care for a period not to exceed 12 months.

A payment is required of non-Category A veterans, seeking non-service-connected outpatient treatment, for each visit, of 20 percent of the estimated nationwide average cost of the Department's outpatient visits during the current fiscal year, but not to exceed, during any 90-day period, the amount of the current inpatient payment ($592).

MISCELLANEOUS

(1) In addition to medical treatment, certain veterans are eligible for dental services, prosthetic appliances and home health care services.

(2) The Secretary may provide skilled or intermediate type nursing care and related medical care in VA or private nursing homes for convalescents or persons who are not in need of hospital care.

(3) The Secretary may furnish needed domiciliary care to any veterans whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of aid and attendance or to any veteran whom the Secretary determines has no adequate means of support.

(4) The Secretary has authority to provide fee-basis care outside of the United States for service-connected disabilities, related to service in the U.S. military forces, to citizens of the Republic of the Philippines or Canada or elsewhere as determined by the Secretary.

BENEFICIARY TRAVEL

(1) During any fiscal year in which the Secretary exercises the authority to make beneficiary travel payments, payments shall be made for travel in connection with examinations, care or treatment (i.e., hospital, nursing home, domiciliary or outpatient treatment) for which the veteran is eligible to:

(a) Veterans for scheduled compensation and pension medical examinations;

(b) Veterans for service-connected disability;

(c) Veterans, with a service-connected disability rating of 30 percent or more, for treatment of any non-service-connected disability.

(d) Veterans in receipt of pension;

(e) Veterans whose annual income does not exceed the maximum annual rate applicable to the non-service-connected pension program;

(f) Veterans for whom ambulance transportation, wheelchair van transportation or other special modes of transportation are medically indicated, and the Secretary determines that the veteran is unable to bear the cost of such transportation (no deductible applies);

(g) Veterans whom the Secretary determines to be unable to defray the expenses of travel or such other persons as determined by regulation.

(2) Eligible veterans will be responsible for the first $6 of the cost of travel to receive VA medical care. For eligible veterans whose medical conditions warrant frequent visits, $18 is the maximum monthly amount for which the veteran will be responsible.

APPENDIX C

Policy Memorandum No.2 - Establishing Teaching Affiliations

January 30, 1946
Policy Memorandum No. 2
Subject: Policy in Association of Veterans' Hospitals with Medical Schools.

1. GENERAL CONSIDERATIONS:

a. Necessity for Mutual Understanding and Cooperation: The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error; and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for post-graduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purpose of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

b. General Division of Responsibility: The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. THE VETERANS' ADMINISTRATION:

a. Operates and administers the hospital.

b. As rapidly as fully qualified men can be had, will furnish full-time chiefs of all services (see paragraph 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the School of Medicine, insofar as the professional care of patients is concerned. Nominations by Deans' Committee for such full-time positions will be welcomed; and unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans' Administration.

c. Appoints the consultants, the part-time attending staff and the residents nominated by the Deans' Committees and approved by the Veterans' Administration.

d. Cooperates fully with the Schools of Medicine in the graduate education and training program.

3. THE SCHOOLS OF MEDICINE:

a. Will organize a Deans' Committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

b. Will nominate an attending staff of diplomates of specialty boards in the numbers and qualifications agreed upon by the Deans' Committee and the Veterans' Administration. (See 6e)

c. Will nominate, from applicants, the residents for graduate education and training.

d. Will supervise and direct, through the Manager of the hospital and the Consultants, the training of residents.

e. Will nominate the consultants for appointment by the Veterans' Administration.

4. HOSPITAL MANAGERS:

a. Are fully responsible for the operation of their hospitals.

b. Will cooperate with the Deans' Committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. CHIEFS OF SERVICE:

a. Are responsible to their superior in the Veterans' Administration for the conduct of their services.

b. Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.

c. Will, together with the part-time attending staff, under the direction of the Manger, supervise the education and training program.

d. When full-time employees of the Veterans' Administration, will be diplomates of their respective boards and will be acceptable to the Deans' Committee and to the specialty boards concerned. It is the urgent purpose of the Veterans' Administration to place full-time fully qualified and certified chiefs of service for all services in each hospital associated with a School of Medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment may not be cleared through the Deans' Committee. In all cases, when it has been conclusively demonstrated that a chief of service cannot cooperate with a Deans' Committee, he will be transferred (if efficient otherwise) and replaced by another.

Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.

6. PART-TIME ATTENDING STAFF:

a. Will be responsible to the respective chiefs of service.

b. Will accept full responsibility for the proper care and treatment of patients in their charge.

c. Will give adequate training to residents assigned to their service.

d. Will be veterans unless approval in each case has been given by the Chief Medical Director.

e. Will be diplomates of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.

f. Will hold faculty appointments in one or another of the associated Schools of Medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. CONSULTANTS:

a. Will be veterans unless approval in each case has been given by the Chief Medical Director.

b. Will be members of the faculty, of professional rank, of one or another of the associated Schools of Medicine.

c. Will, as representatives of the Schools of Medicine, direct and be responsible for the educational training of residents.

d. Will afford to the Manager and the proper Chief of Service the benefit of their professional experience and counsel.

e. Will conduct their duties through, and in cooperation with, the Manger and the proper Chief of Service, and also, in matters of education and training, with the part-time Attending Staff—always, however, coordinating with the Chief of Service.

APPENDIX D
GLOSSARY

ADC -- *Average Daily Census*: Average number of patients cared for per day during the reporting period.

ADHC -- *Adult Day Health Care*: A program which provides medical, rehabilitative, social, recreational and health education services to veterans in a congregate setting during normal working hours.

ACGME -- *Accreditation Council of Graduate Medical Education*

AHA -- *American Hospital Association*

ALOS -- *Average Length of Stay*: Number of inpatient days for discharged patients divided by total number of discharges; equivalent to the average number of days for an inpatient episode of care.

Ambulatory Care: Medical treatment which is provided without a requisite overnight hospital stay, including some forms of surgery; non-emergency examination; diagnosis and treatment of medical conditions; and, laboratory and other diagnostic testing. Synonymous with outpatient care.

AMVETS -- *American Veterans of WW II, Korea and Vietnam*: A veterans service organization and sponsor of the Independent Budget.

C&P -- *Compensation and Pensions*: The organizational component of the Veterans Benefits Administration that processes veterans' claims and administers payments for compensation and pension benefits.

Capital Facilities Inventory: A system recommended by the VSOs to maintain a current information base which would enable VHSRA to determine needs for major construction projects.

Category A Veterans: Those service-disabled veterans, ex-POWs, Veterans of World War I or earlier conflicts, veterans exposed to ionizing radiation and Agent Orange, VA pension recipients, veterans with Medicaid, and other low-income veterans. Category A Veterans are entitled to the provision of hospital and some forms of outpatient care; see Appendix B.

CIARDS -- *CIA Retirement and Disability System*

CMD -- *Chief Medical Director*: Head of the Veterans Health Services and Research Administration (VHSRA); reports to the Secretary of the Department of Veterans Affairs.

COLA -- *Cost of Living Adjustment*: Increase in benefits to compensate for rise in the cost of living due to inflation; usually provided on a yearly basis.

Compensation: The appropriation account that provides for compensation payments to service-connected disabled veterans and their survivors.

CRC -- *Community Residential Care Program*: Provides residential care to veterans who do not require hospital or nursing home care but who cannot live independently; cost of this care is paid by the veteran.

CSRS -- *Civil Service Retirement System*

DAV -- *Disabled American Veterans*: A veterans service organization and sponsor of the Independent Budget.

DHHS -- *Department of Health and Human Services*

DIC -- *Dependency and Indemnity Compensation*: Paid to the surviving wives or children of servicemen or veterans whose death occurred while on active duty or as a result of service-connected disabilities.

Discharge Rate: The ratio of the number of inpatients treated to the client population base; usually expressed as a rate, inpatients per 1000 veterans.

DoD -- *Department of Defense*

Eligibility *(for VA medical care system treatment)*: Eligibility criteria are categorized by service-connected status and income levels and other factors; eligible veterans may receive VA health services if space and resources are available service-connected veterans are eligible for the full spectrum of VA medical care services; see Appendix B for entitlement and eligibility criteria.

Entitlement: Benefits: VA is required to provide benefits to those veterans who are entitled to programs under Veterans Benefits Administration criteria. Medical Care: VA is required to provide inpatient and some forms of outpatient care to veterans entitled to VA medical care system treatment; see Appendix B for entitlement and eligibility criteria.

FDPP -- *Facility Development Planning Program*: A component of the current Medical Care Construction Program used by VHSRA to identify individual medical centers' current and projected facility needs.

FERS -- *Federal Employees Retirement System*

FTEE -- *Full-time Employee Equivalent*

GAO -- *General Accounting Office*

GEM -- *Geriatric Evaluation and Management Unit*: Units at VA medical centers that assess elderly patients' medical, functional, psychological and environmental conditions.

GIF -- *Guaranty and Indemnity Fund*: Authorized by the Veterans' Benefits Amendments Act of 1989, this fund finances all operations of the loan guaranty program for loans closed on or after January 1, 1990, except manufactured home loans guaranteed under 38 U.S.C. 1812, loans guaranteed under section 1811(g) and most administrative costs. The principal objective of the fund is to encourage and facilitate extension of favorable credit terms by private lenders to veterans for the purchase, construction or improvement of homes to be occupied by veterans and their families.

GOE -- *General Operating Expenses*: The appropriation account for the administration of all VA non-medical benefits and support functions for the entire Department; includes the Veterans Benefits Administration, the National Cemetery System and the General Administration activities.

GRECC -- *Geriatric Research, Education and Clinical Center*: VA centers that advance geriatric and gerontological research, education and clinical achievements and their integration into the VA health care system.

HBHC -- *Hospital-Based Home Care*: Programs which allow the early discharge of chronically ill veterans to their own homes.

HCMI -- *Homeless Chronically Mentally Ill Veterans Program*: A VA outreach program to identify and serve homeless chronically mentally ill veterans.

HLGP -- *Home Loan Guaranty Program*: Provides housing credit assistance to eligible veterans and military personnel.

Hospice Program: Provides inpatient palliative care for terminally ill patients.

HPSP -- *Health Professions Scholarship Program*: Provides physician, nurse, physical therapist and other health professions scholarships.

HVAC -- *House Veterans Affairs Committee*

In-house Associate Degree Program: VA program under which candidates receive VA salary for part-time employment and expense reimbursement when pursuing a health profession associate degree, in return for obligatory VA service.

Inpatient Services: Those services which require patient admission to a health care facility.

Intermediate Care: An extended care bed section in a VA hospital.

IRM--*Information Resources Management*: A strategy based on the principle that information is a resource that should be managed from the highest level of an organization.

JCAHO -- *Joint Commission on Accreditation of Health Care Organizations*: Provides criteria for hospital accreditation. JCAHO standards are used by VA to assess quality of medical care.

LGRF -- *Loan Guaranty Revolving Fund*: Funds the non-administrative expenses incident to the management and sale of properties acquired when program borrowers fail to keep up their payments on VA guaranteed or insured loans. Revenue is derived principally from the sale of homes for cash, sale of loans and a funding fee.

Long-term Care: Non-acute care services requiring treatment of more than 30 days.

Major Construction: Construction projects costing $3 million or more; also the name of the appropriation account that funds such projects.

MAMOE -- *Medical Administration and Miscellaneous*

Operating Expenses: The appropriation account that provides for the administration of all medical programs of the VA.

Medical Care Cost Recovery: Program to collect veteran co-payments and reimbursable costs from third-party insurers for medication and health care services.

Minor Construction: Construction projects costing less than $3 million; also the name of the appropriation account that funds such projects.

NCS -- *National Cemetery System*: The VA agency responsible for interment and related services for deceased veterans, active duty members of the armed forces and their eligible dependents.

Non-Service Connected Patients: Veteran patients who do not have a military service-related injury or illness.

NSLI -- *National Service Life Insurance*: Trust fund started in 1940 as the financing mechanism for World War II insurance. Closed to new issues in 1951. Income is derived from premiums, interest on investments and transfers from Veterans Insurance and Indemnities appropriation.

OASDI -- *Old Age, Survivors and Disability Insurance Benefits*: Social Security Benefits Program.

OBRA -- *Omnibus Budget Reconciliation Act of 1990*: An act to meet 1995 deficit reduction targets.

Occupancy Rate: Ratio of average daily census to the average number of beds in a reporting period.

OMB -- *Office of Management and Budget*

OSHA -- *Occupational Safety and Health Administration*

Outpatient Care: See Ambulatory Care.

Outpatient Use Rate: Ratio of the total number of outpatient visits to the total veteran population.

Outpatient Visits: Visits by patients who are not lodged in the hospital while receiving medical, dental, or other services. A visit consists of one or more clinic stops. (Each test, examination, treatment, or procedure rendered to an outpatient counts as one clinic stop.)

P&SAS -- *Prosthetics and Sensory Aids Service*: The entity within VHSRA whose goal is the timely and appropriate provision of prosthetic and orthotic appliances and sensory aids to veterans.

Pensions The appropriation account that provides for pension payments, subject to an income standard, to war-time veterans who are permanently and totally disabled from non-service connected causes and their survivors.

Pharmaceutical Unit Dose Program: A system that minimizes pharmacy costs by packaging and dispensing drugs in single dose quantities.

PTSD -- *Post-Traumatic Stress Disorder*: A psychiatric condition caused by a traumatic experience, such as combat.

PVA -- *Paralyzed Veterans of America*: A veterans service organization and sponsor of the Independent Budget.

QMMP -- *Quality Measurement and Management Project*: The American Hospital Association's project established to design a system for monitoring quality assurance through outcome indices.

Quaternary Care: Intensive, high cost therapy for major illness or injury, utilizing specialized professional teams.

RAM--*Resource Allocation Model*: Formerly, system for distribution of resources in VA system based on Diagnostic Related Groups (DRGs).

RB -- *Readjustment Benefits*: The appropriation account that provides payments for education and training, for eligible veterans and dependents, as well as special assistance to disabled veterans.

Respite Care: Programs under which elderly or disabled persons are institutionalized periodically to allow a relief period for the patient's care-giver.

RO -- *Regional Office*:

Benefits: An office in one of fifty-eight geographical areas responsible for administering veterans' benefits.

Medical: An office in one of four geographical areas responsible for administering medical care benefits to veterans.

RPM -- *Resource Planning and Management*: Strategy formulated by the Veterans Health Services and Research Administration to achieve comprehensive integration of strategic and operational planning, budgeting and operational management of the VA health care system consistent with the VA National Health Care Plan.

SDVI -- *Service Disabled Veterans Insurance*: The fund financing claim payments on non-participating policies issued to service-disabled veterans who served in the Armed Forces after April 25, 1951. The program provides insurance coverage for service-disabled veterans at standard rates. Claim payments exceed premium receipts each year. Funds are derived mainly from premiums and payments from the Veterans Insurance and Indemnities appropriation.

Secondary Care: Therapy for acute short-term illness or injury.

SERP -- *Systematic External Review Program*: VA's ongoing system of peer review used to evaluate quality.

Service Connected Patient: A veteran with conditions resulting from illness or injuries sustained during military service.

SSA -- *Social Security Administration*

SSI -- *Supplemental Security Income*: Social Security counterpart to Veterans Pension Program.

Suppressed Demand: The difference between the expected workload of a given health care setting and the actual workload. Suppressed demand results from inadequate operating resources and is manifested by turnaways and unmet needs.

SVAC -- *Senate Veterans Affairs Committee*

Tertiary Care: Definitive therapy for major illness or injury, utilizing specialized professional talent and techniques.

Unmet Need: The difference between the health care needs of a population and the health care services actually delivered.

USGLIF -- *U.S. Government Life Insurance*: Trust fund started in 1919 as the financing mechanism for converted insurance issued under War Risk Insurance Act of 9/2/14, as amended. Closed to new issues April 1951. Income is derived from interest on investments and transfers from Veterans Insurance and Indemnities appropriation.

VA -- *Department of Veterans Affairs*: formerly, Veterans Administration.

VACO--*Veterans Affairs Central Office*

VAMC -- *Veterans Affairs Medical Center*

VBA -- *Veterans Benefits Administration*: The Veterans Affairs component that administers the VA's non-medical benefits and services to veterans and their dependents (formerly VA's Department of Veterans Benefits).

VFW -- *Veterans of Foreign Wars of the United States*: A veterans service organization and sponsor of the Independent Budget.

VHSRA -- *Veterans' Health Service and Research Administration*: The VA agency responsible for delivery of medical care; formerly VA's Department of Medicine and Surgery.

VI&I -- *Veterans Insurance and Indemnities*: The appropriation that provides payment for extra hazard costs to the National Service Life Insurance, United States Government Life Insurance, supplements the Service-Disabled Veterans Insurance Fund and provides direct payment to policyholders; also provides funds for expenses of the Veterans Mortgage Life Insurance Program.

VMLI -- *Veterans Mortgage Life Insurance Program*: A program funded by the Veterans Insurance and Indemnities appropriation. The program provides $40,000 in mortgage life insurance to individuals who have received a grant for specially adapted housing. Policies are issued at standard premium rates to individuals who are considered health risks.

VR&C -- *Vocational Rehabilitation and Counseling*: The component of the Veterans Benefits Administration that assists veterans who have service-connected disabilities.

VS -- *Veterans Services*: The component of the Veterans Benefits Administration that provides information, advice and assistance regarding benefits to veterans and their dependents and survivors.

VSO -- *Veterans Service Organization*

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STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

PRESENTATION BEFORE THE

HOUSE VETERANS AFFAIRS COMMITTEE

FY-92 BUDGET HEARING

Presented by
Kenneth I. Shine, M.D.
Dean
University of California, Los Angeles
School of Medicine

Thursday, February 21
9:30 a.m.
334 Cannon House Office Building

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0525

Mr. Chairman, it is an honor to be invited back to testify before the House Veterans' Affairs Committee on the status of funding for the Department of Veterans Affairs (VA) medical care and research programs. I am Kenneth I. Shine, M.D., Dean of the University of California, Los Angeles (UCLA) School of Medicine. I appear today as a representative of the Association of American Medical Colleges (AAMC) and the Friends of VA Medical Care and Health Research. The AAMC represents the nation's 126 medical schools, over 90 professional and academic societies, and 420 major teaching hospitals, including 72 VA medical centers. Currently, 139 VA facilities are affiliated with 102 medical schools, illustrating the strong ties that the AAMC and its member institutions have with the VA.

The AAMC takes seriously the important role of the VA in educating future health care providers and is committed to supporting the needs and overall mission of the VA. As such, the AAMC joins with over 100 other scientific, academic, research, and voluntary health organizations in a coalition called the "Friends of VA," to advocate for increased funding for the VA's medical care and research programs. I request that the Committee include in the hearing record the FY-1992 budget proposal prepared by the Friends of VA.

The basis of VA medical center-university affiliation agreements is a model for public-private partnerships. Since the end of World War II, medical schools and the VA have joined in symbiotic relationships that improve the quality of care delivered to veterans, play a critical role in staffing the VA, and help train young physicians. In fact, half of the nation's medical students spend a portion of their time in the VA system.

UCLA enjoys affiliations with three VA medical centers in Southern California: Wadsworth, a flagship hospital with an impressive research program; Sepulvada, a pioneer in improving the delivery of health care for geriatric patients and for utilizing the ambulatory setting to treat veterans; and Brentwood, a major psychiatric care facility. When I appeared before this Committee almost exactly two years ago, I explained some of the problems and challenges experienced by these VA medical centers and UCLA as a result of budget shortfalls. We discussed difficulties such as inability to recruit and retain professional staff, unmet equipment needs, infrastructure decay and declining staff morale. All of these factors contributed to erosion in the quality of care delivered to veterans and a strain on affiliations. Two years later, similar problems persist in California and nationwide.

I realize that the VA medical care account has received what looks like impressive budget increases in the past two years, and that the Administration recommended an additional $976 million for FY-92. Medical care has gone from funding of $10.65 billion in FY-89 to $12.3 billion in FY-91, and a projected $13.29 billion for FY-92. However, when the overall appropriation is adjusted for inflation and employment-related costs, (using the general CPI, not the medical CPI, which as you know is much higher) the VA medical care budget has remained stagnant. In fact, the VA medical care budget remained flat throughout the 1980's, during which time workload multiplied. Workload increases are partially the result of new statutory mandates, as well as factors including meeting the health care needs of the aging VA patient population and treating a large share of veterans who have AIDS. (See attached charts 1-3.) Furthermore, previous and proposed funding levels for the VA research program fail to reflect the importance of this portion of the VA's mission.

I do not enjoy being in the position of saying that $1.5 billion in two years is not enough, nor that an additional $976 million will not cover projected costs, particularly in a time of a national efforts to control spending. However, I would do a disservice to veterans and the VA if I did not share with you my personal and professional assessment of the needs of the system. And, the fact is the funding increases provided in recent years have not been sufficient to recover from previous shortfalls. Core programs will continue to suffer. The VA will still face serious problems with outmoded equipment, waiting periods for outpatient visits, inadequate supplies, staff shortages, and closed beds. In other words, the quality of care will continue to be compromised and VA affiliates will still question the appropriateness of the VA's educational environment.

For example, this Committee has heard testimony about how medical schools subsidize VA salaries, often substantially. The growing disparity between university and VA salaries increases the importance and extent of this practice, at a time when universities are facing funding constraints of their own, and a reduced ability to provide subsidies. The pay reform legislation will go a long way to improve the situation, only if appropriate funding is provided. The Administration's budget includes $41.5 million for physician and dentist pay, however, the package is estimated to cost $63 million. It is essential that full funding is provided so that the VA is not forced to "cannibalize" other accounts to meet payroll-related expenses.

Similarly, the Administration budget provides only $52 million for replacement equipment. Two years ago, VA officials told this Committee that the system had an equipment backlog estimated at nearly $1 billion. Current estimates place the cost of equipment replacement at over $750 million. Clearly, the system cannot continue to sustain chronic shortfalls in such critical areas.

Budget recommendations for FY-92 must include an adjustment for the previous lack of resources. To ignore such an adjustment would perpetuate the damage caused by past under-funding. Taking into account such items as general inflation, payroll increases, workload expansion, and equipment and facilities needs, the FY-91 appropriation of $12.3 billion would require an increase of $1.7 billion, or a total of $14.02 billion, to maintain "current services" in FY-92.

The Friends of VA share the views of the "Independent Budget" that total FY-92 medical care appropriations should be $14.89 billion. Funding at this level would allow the VA to recover from previous shortfalls and begin to prepare for future needs. The Friends of the VA recommend $870 million for system enhancements for programs such as:

1. expanding geriatric care -- through Geriatric Evaluation and Management Units (GEMs), Geriatric Research, Education and Clinical Centers (GRECCs), and long

term care facilities to meet the needs of the elderly veteran population;

2. increasing outpatient workload -- the ambulatory setting is a cost-effective means for delivering care that is often more comfortable and convenient for the patient and family, but establishing such sites requires capital commitments;

3. promoting mental health -- focusing resources on illnesses such as post-traumatic stress disorder and substance abuse, and by establishing Mental Illness Research, Education and Clinical Centers; and

4. extending education and training -- by building on programs such as health professions scholarships and continuing education.

As I mentioned earlier, the Administration's budget fails to recognize the importance of the VA research program. Mr. Chairman, this Committee is familiar with the benefits of VA research. Funds dedicated to research bring multi-faceted benefits, including assisting recruitment and retention, improving the quality of care, and producing knowledge that is used to improve the health of veterans and the population as a whole. In earlier hearings, you have heard about the critical role research plays in recruitment and retention. The existence of the research program attracts to the VA leading physicians who are committed to providing clinical care to VA patients and studying the diseases that afflict veterans. A few examples of discoveries made by VA clinician-scientists include:

1. a non-surgical procedure to treat prostrate enlargement that could save the VA up to $29 million annually;

2. an outpatient alcohol detoxification treatment program that is as effective as inpatient treatment, but 90 percent less costly;

3. a means of treating high blood pressure with lower levels of medication, thereby reducing toxic side-effects and costs; and

4. the successful evaluation of implantable insulin pumps in diabetic patients that could eliminate the need for daily insulin injections.

Last year, Secretary Derwinski convened an 18-member panel called the Department of Veterans Affairs Advisory Committee for Health Research Policy, known as the "Blue Ribbon Commission." After a year-long study of the VA research program, the Commission forwarded a final report to Secretary Derwinski on January 31. I commend the report to your attention and request that the text be included in the hearing record. To quote from the report:

> "The VA Advisory Committee for Health Research Policy, after careful examination of all components and activities of the Department of Veterans Affairs which bear on health research, concludes that this aspect of Departmental operations is vital to the continued ability of the VA to provide high quality health and medical care to its veteran constituency. The quality of VA-sponsored research in all areas remains high and on a par with health research supported by the NIH and other governmental agencies sponsoring health research. Yet, recent decreases in the financial support of VA research has led to unwise curtailment of Central Office research staff support for this program, reduced the number of approved projects that can be funded (though there has been a fourfold increase in the number of approved but unfunded projects), and is likely to reduce the attractiveness of VA employment for highly qualified physicians who might be recruited and retained by the system."

The Committee concluded that an FY-92 funding level of $280 million would be necessary to restore the vitality of the program. This level of support would return the

VA research program to the FY-85 level of effort, in terms of the number of projects funded. I have attached two charts (numbers 4 and 5) that illustrate that the VA research program has lost buying power in recent years, while the number of approved/unfunded grants has increased.

While this Committee has recommended increases in research support, recent Administration budgets have not. Last year, the Administration recommended a $14 million real cut in the VA research program; Congress supplied funds to achieve two percent growth in the program. For FY-92, the Administration recommended no increase. I urge the Committee to adopt the FY-92 budget recommendations of the Blue Ribbon Commission. The Friends of the VA and the Independent Budget have included the Commission's recommendations in their own FY-92 budget proposals.

In concluding, I would like to draw attention to the fact that for the first time since the VA's four missions have been explicitly outlined, the Department has been called upon to exercise its role as emergency support for the Department of Defense. This is an appropriate and important role. The VA is in a unique position to provide specialized care for the military and has the advantage of drawing on the support of affiliated universities to prepare quickly for an increased workload of a severe nature. I understand that the VA has already devoted some resources, although under $5 million, for emergency preparedness and that the Department negotiated an agreement for repayment from the DOD for the costs of treating war causalities. I am impressed by the VA's commitment and foresight. I urge Congress to monitor this situation carefully and to provide additional resources, if necessary, to ensure the VA's ability to meet this important task.

Mr. Chairman and Members of the Committee, thank you again for the opportunity to testify this morning. I will be happy to answer any questions.

CHART 1

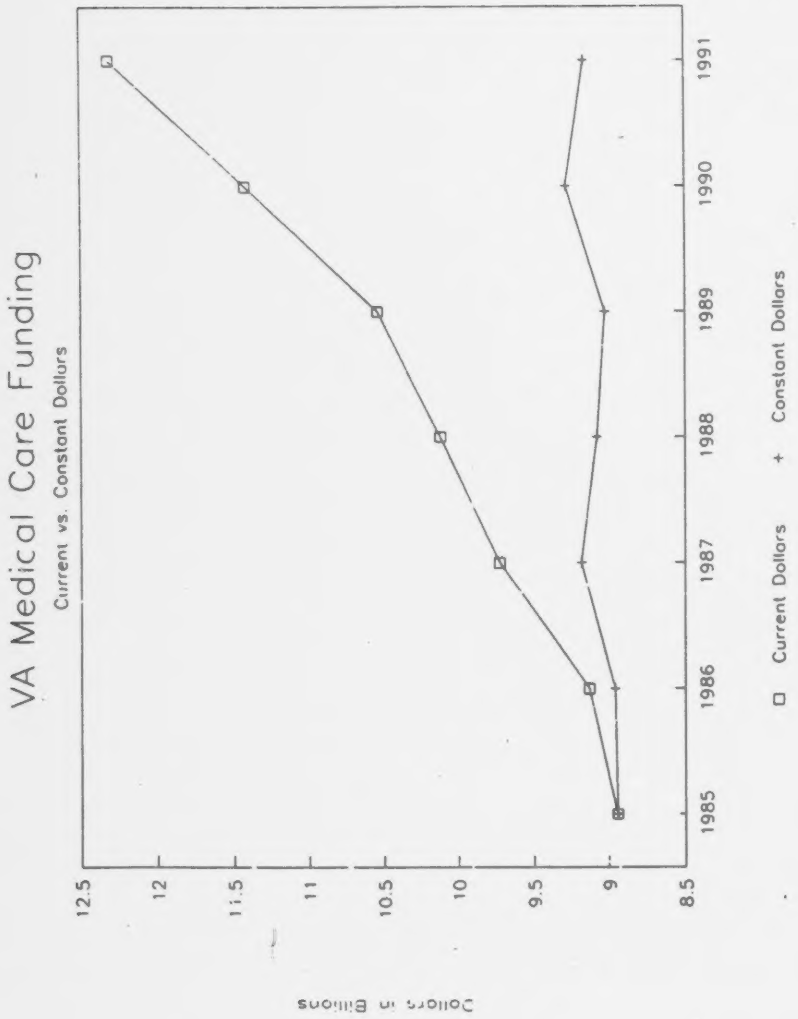

VA Medical Care Funding
Current vs. Constant Dollars
Dollars in Billions
12.5
12
11.5
11
10.5
10
9.5
9
8.5
1985
1986
1987
1988
1989
1990
1991
□ Current Dollars
+ Constant Dollars

CHART 2

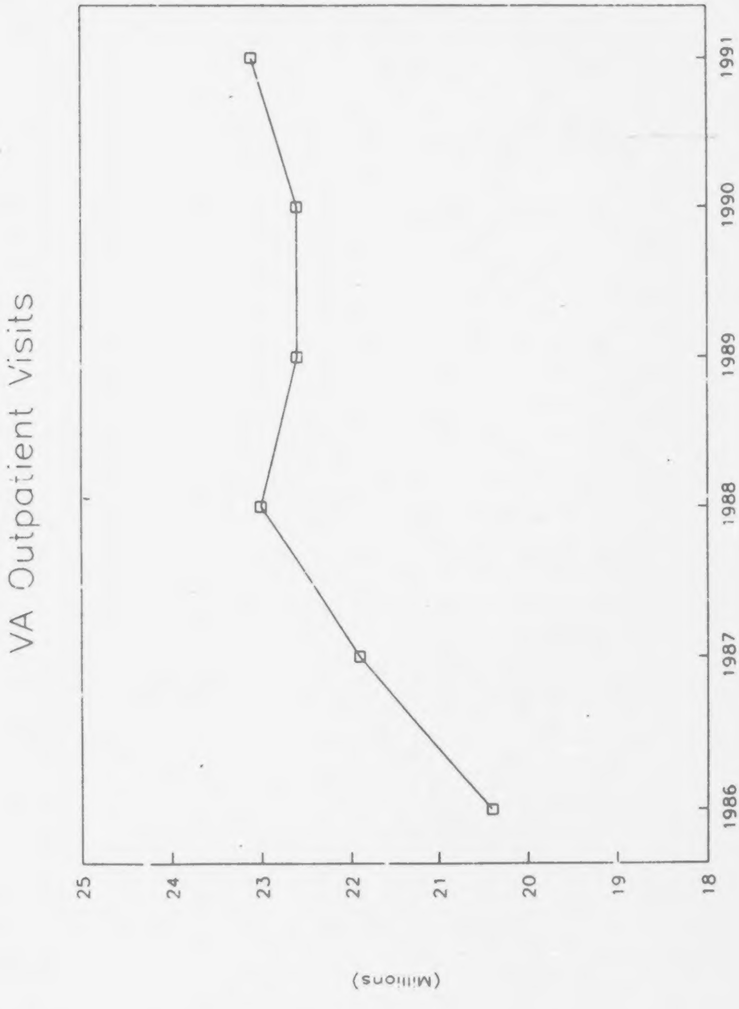

VA Outpatient Visits
(Millions)
25
24
23
22
21
20
19
18
1986
1987
1988
1989
1990
1991

CHART 3

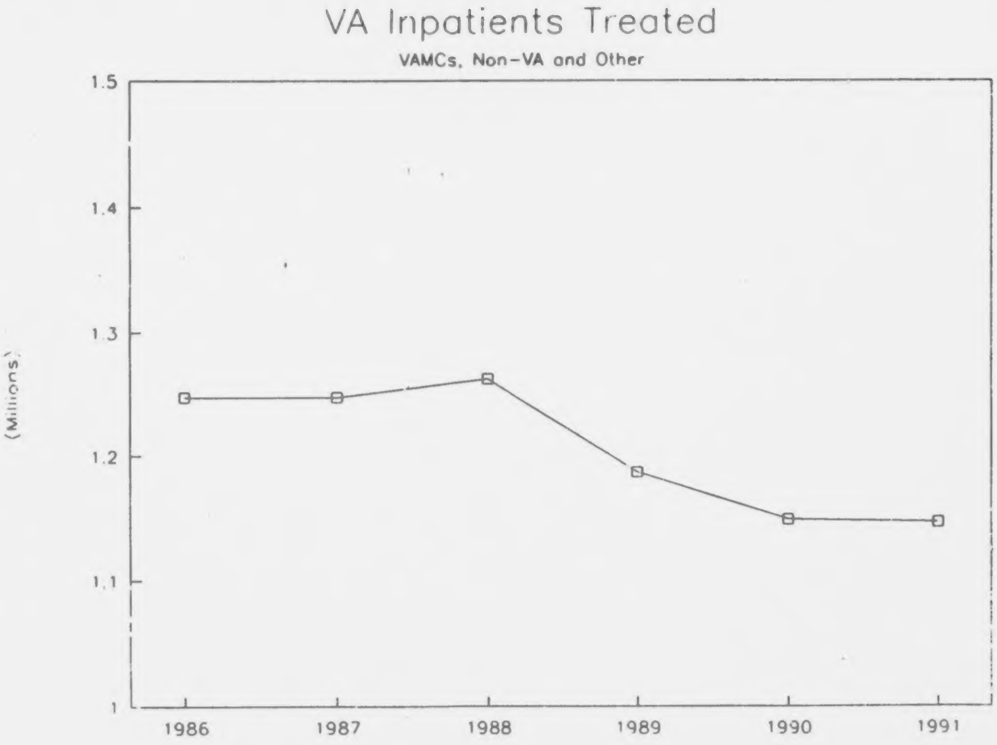

VA Inpatients Treated
VAMCs, Non-VA and Other
(Millions)
1.5
1.4
1.3
1.2
1.1
1
1986
1987
1988
1989
1990
1991

CHART 4

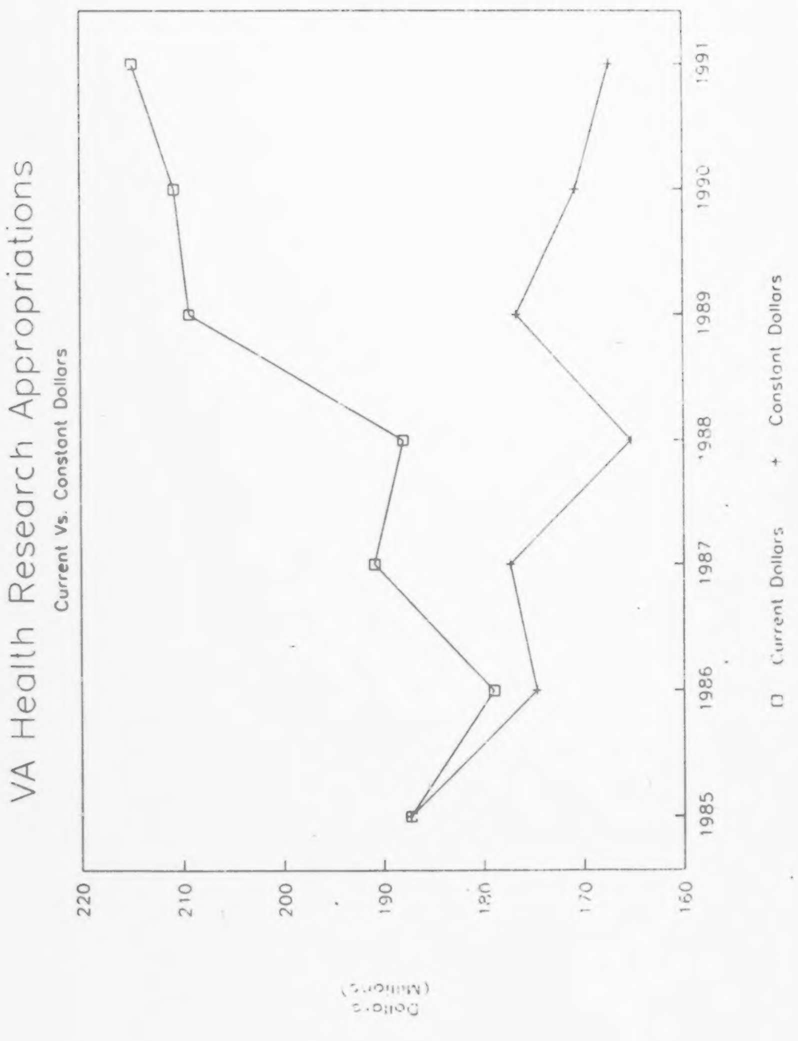
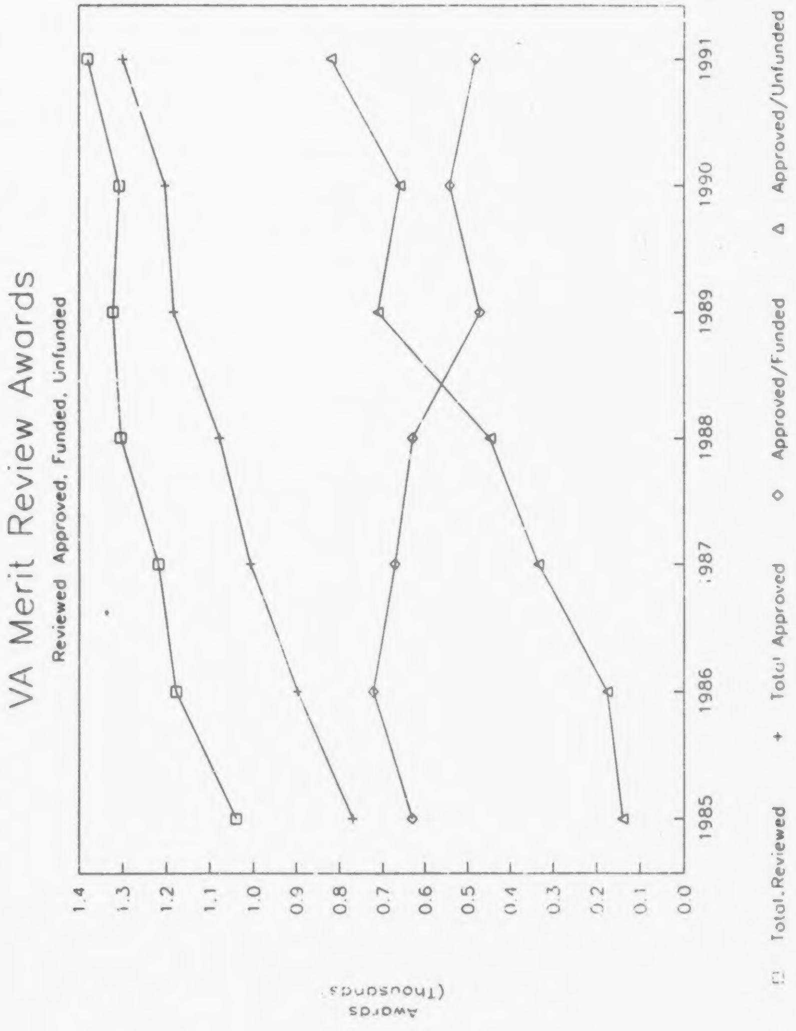

VA Health Research Appropriations
Current Vs. Constant Dollars
Dollars (Millions)
220
210
200
190
180
170
160
1985
1986
1987
1988
1989
1990
1991
□ Current Dollars
+ Constant Dollars

CHART 5


VA Merit Review Awards
Reviewed Approved, Funded, Unfunded
Awards (Thousands)
1.4
1.3
1.2
1.1
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
1985
1986
1987
1988
1989
1990
1991
□ Total Reviewed
+ Total Approved
◇ Approved/Funded
△ Approved/Unfunded

FINAL REPORT
of the
DEPARTMENT OF VETERANS AFFAIRS ADVISORY COMMITTEE FOR HEALTH RESEARCH POLICY
January, 1990 - January, 1991

REPORT OF THE VA ADVISORY COMMITTEE FOR HEALTH RESEARCH POLICY

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THE CHARGE TO THE COMMITTEE

The Department of Veterans Affairs (VA) Advisory Committee f Health Research Policy (Committee) was appointed by Secretary Derwinski in January 1990 to review VA research programs. Specifically, the Committee was asked to address the following questions:

>Is VA research appropriately balanced among health research subject areas?

>Is VA research appropriate to the role of the VA in providi medical and other health care services to veterans?

>Is the VA research program appropriate vis-a-vis the role of other federal agencies, including NIH?

>What is the overall quality of the VA research program?

Additionally, at its first meeting on February 28, 1990, Secretary Derwinski requested that the Committee recommend a budge for VA research for Fiscal Year 1992.

To address the Secretary's charges, the Committee collected information about the VA research program from the VA Central Offi staff, met with research leaders in the VA and the Department of Health and Human Services, conducted site visits at selected VA medical centers, and solicited the views of a wide spectrum of national organizations concerned with VA research. The members of Committee also observed the process of VA peer review of research proposals and reviewed the administrative functions of the research program in the VA Central Office. In addition, public comments wer received during the meetings of the Committee.

This report summarizes the findings and recommendations of the Committee. These include responses to each of the Secretary's direct questions, research budget recommendations for Fiscal Year 1992, and recommendations regarding future management of VA research programs.

INTRODUCTION: HISTORY AND DESCRIPTION OF VA RESEARCH

The VA research program was launched immediately after World War II as part of an effort to upgrade rapidly the quality of VA patient care by affiliating VA medical centers with medical schools. Affiliated VA medical centers adopted the academic medical care model in which physicians and other health care professionals provide medical care for veteran patients; teach medical students, residents, and other health professionals; and carry out active research programs. This model has led to the development of a substantial number of world-class VA medical centers that provide state-of-the-art care to veterans; serve as referral centers for all VA hospitals; train new practitioners; and contribute, through research, to the advancement of medical practice. The Committee believes this mission encompassing teaching, research, and medical care should be maintained and, to the extent possible, enhanced. In this connection, the Committee expresses concern that the recent budget reductions in VA medical research threaten the viability of the academic medical model in VA medical centers. These budget reductions should be reversed if the VA is to maintain the high quality of patient care it has achieved through medical school affiliation.

Direct support for VA research began modestly in 1946, grew rapidly in the mid-1950s to mid-1960s, stabilized from 1970 to 1985, and dropped for several years thereafter (see Figure 1, Page 18). Most of the VA research support has been awarded to physician principal investigators through the VA's Medical Research Service

(MRS). These MRS funds provide salaries for research technicians and allow the purchase of research equipment and supplies to support studies in such areas as heart disease, cancer, stroke, diabetes, mental illness, and substance abuse as well as disabilities related t them. Consistent with national medical research policy, VA MRS funds have been awarded on the basis of the quality of proposed studies to individual researchers, who conceptualize, design, and carry out funded studies.

The VA's medical research program serves two major functions: (1) to attract, educate, and retain superbly trained, research-oriented physicians at VA medical centers; and, (2) to advance the diagnosis and treatment of health problems prevalent among veteran patients by applying the findings of VA medical research studies throughout the system.

In addition to supporting medical research, the VA has two administratively separate programs that fund studies in rehabilitatio research and development (RR&D) and health services research and development (HSR&D). The VA's RR&D program also began in the immediate post-WWII era in response to the need for improved prostheses for returning veteran amputees. The primary function of the current RR&D program is the development of devices to improve the quality of life of disabled veterans in need of prosthetic devices, sensory aids, and mobility assistance; the VA program has become the mainstay of this type of research in the United States.

The HSR&D program was formally established in 1973 to investigate factors relating to the existing organization, delivery, costs, and outcomes of VA health care programs by supporting peer reviewed research on issues related to the improvement of the quality, efficiency, and cost-effectiveness of health care provided by the VA. Examples of significant VA health services research include the first demonstration of the cost-effectiveness of geriatric evaluation units in the care of elderly patients and a recent study demonstrating that many alcoholic patients in need of detoxification can be treated more cost-effectively as outpatients than as inpatients.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

I. IS VA RESEARCH APPROPRIATELY BALANCED AMONG HEALTH RESEARCH SUBJECT AREAS?

In general, the Committee finds that the VA research program is appropriately balanced among subject areas but is inadequately supported to achieve its goals.

The question of programmatic and budgetary balance within a broad-based health care research program is complex. The Committee makes two major recommendations:

(1) Allocation of funds among research subject areas should be reviewed periodically to assess scientific significance and relevance to the VA mission.

(2) The Committee reaffirms a prior recommendation made by the National Academy of Sciences in 1977 and advises the Secretary to create a Health Research Advisory Council to oversee all aspects of research (including investigations in prosthetics and orthotics) and to identify and prioritize those areas of investigation that hold the greatest promise of improving the VA's ability to prevent, diagnose, and treat veterans' medical problems.

The Committee maintains that such a Council should include scientists from those preclinical, clinical, and other scientific disciplines that are relevant to VA health-related research.

The proposed Research Advisory Council should assist in supporting VA scientists by advising on the expansion of ongoing research activities, where needed, and by suggesting ways of expandir the VA research effort into areas of new opportunity. While funding new initiatives that reflect emerging priorities, care should be take to ensure that expansion occurs without undermining the VA research infrastructure and without creating funding instabilities that are likely to contribute to the loss of physician-investigators.

The proposed Council should review funding decisions, program priorities, and the balance across research areas and report to the Secretary, Department of Veterans Affairs, or his designee.

II. IS VA RESEARCH APPROPRIATE TO THE ROLE OF THE VA IN PROVIDING MEDICAL AND OTHER HEALTH CARE SERVICES TO VETERANS?

The Committee strongly believes that the research program of the VA is entirely appropriate to its clinical mission. By design, the VA's research program primarily supports physician-investigators who are involved in direct patient care, assuring an orientation toward and priority for solving problems related to diseases of veteran patients.

Since the VA has a vigorous research program, which is essential to provide the best care for veteran patients, the system is able to attract a high quality house staff and attending physicians who are faculty members of affiliated medical schools. These two elements combined--the high quality staff and the research-driven care--enable the VA to provide superior services that could not be purchased in the private sector.

The Committee endorses the funding strategy adopted by the VA in response to recommendations of the 1977 National Academy of Sciences review, which allocates research funds on the basis of the quality of the research proposed by individual investigators and favors an ongoing evaluation and recommendation of major new research directions by the proposed Health Research Advisory Council. Some of the topical areas recommended for the proposed Council's early consideration are chronic obstructive pulmonary disease, hypertension, improvements in cancer therapy, cardiac disorders, mental illness, alcohol and substance abuse, and geriatrics.

III. IS THE VA RESEARCH PROGRAM APPROPRIATE VIS-A-VIS THE ROLE OF OTHER FEDERAL AGENCIES, INCLUDING NIH?

The Committee concludes that VA funded research is appropriate compared to the research programs of other funding sources and plays a complementary role in the fabric of the nation's biomedical research community. While the mission of NIH is to foster the highest quality health research and research training for the country at large, the primary mission of the VA research program is specifically to foster high quality research within VA medical centers. The special strength of VA research is the high degree of physician involvement, which has been found to be essential for recruiting and retaining outstanding physicians and other health professionals and for assuring provision of the best medical care in an atmosphere of scientific inquiry.

The VA biomedical and behavioral research programs provide uniq research opportunities. Collaborative, multi-center clinical trials are highly successful within the VA medical system because it is a single organization with access to a large number of patients who ca be enrolled and carefully followed over an extended period of time t study the short- and long-term consequences of health care interventions. Additionally, a number of medical, neurologic, psychiatric, and behavioral problems can be efficiently studied in t VA system because of the large number of veteran patients with these conditions. The long-term hospitalization and nursing care for thes disorders occurs mainly within VA medical centers and associated nursing homes. The VA is also an important resource for the study o health care delivery and management issues, including those related t continuity of care and cost-effectiveness of various approaches.

As the competition for NIH extramural funding intensifies, VA research support becomes an increasingly important source of funding for clinically relevant studies. Adding further emphasis to this point is the fact that 75% of NIH's funding is awarded to non-clinician Ph.D. scientists, who are less likely than physicians to be interested in clinical research, while 75% of VA-funded investigators are M.D. scientists.

The VA became a leader in research and practice of geriatric assessment and management by responding to the needs of the disproportionately high numbers of aging veterans by setting up Geriatric Research, Education and Clinical Care Centers (GRECCs) beginning in 1975. The Committee advises the Secretary to consider similar initiatives in other clinical and research areas. For example, clinical care centers, such as the Mental Illness Research, Education and Clinical Care Centers (MIRECCs), could be considered as one means of increasing opportunities for research in psychiatric disorders. Similar centers could be established in such areas as cancer detection and therapy, chronic obstructive pulmonary disease, and cardiovascular disorders. These centers could provide a way to deal with the emerging priorities in the VA and the nation at large.

IV. WHAT IS THE OVERALL QUALITY OF THE VA RESEARCH PROGRAM?

The Committee concludes that the overall quality of VA research is exceptionally high. Evidence to support this conclusion is provided by at least five valid indicators:

>First, after careful deliberations and on-site reviews, the Committee found the VA's system to be of the highest quality and on a par with the NIH system. The excellence of the VA's peer review program has been a major achievement of the last decade.

>Second, in FY 1989, VA investigators received over $163 million of support for 4,240 projects from sources other than the VA. More than $116 million was awarded through peer-reviewed research grants

from federal agencies; the largest amount, $83 million, came from NIH and ADAMHA. An additional $47 million was awarded to VA investigator from the private sector. This funding success clearly reflects the ability of VA investigators to compete in multiple health research fields.

>Third, two VA investigators have received the Nobel Prize, and many others have received other prestigious national and internationa research honors.

>Fourth, the Cooperative Studies Program has generated, over the past 13 years, more than 300 landmark publications that have defined many aspects of the "state-of-the-art" in contemporary medical practice. Nationally and internationally recognized contributions have also been made in prosthetics, sensory aids, and health services research.

>Fifth, supplementary salary support has been provided to VA investigators by affiliated medical schools. In view of the scarce resources of medical schools, such commitment of funds attests to the high quality of medical research undertaken by VA researchers and is recognition of their role as educators and health professionals.

V. RECOMMENDATIONS FOR RESEARCH SUPPORT FOR FY 1992.

The Committee developed the following recommendations regarding research support for FY 1992:

(1) **Funding for the Medical Research Service should be increased.** Past trends of declining dollar levels of support for the Medical Research Service have resulted in substantial decreases in the number of funded proposals and, consequently, in the number of funded VA physician-investigators.

Comparison of Merit Review Proposals Submitted, Approved, and Funded in Years 1986 and 1990

Merit Review Proposals	1986	1990
Total number submitted	1,140	1,250
Number funded	722 (63.3%)	542 (43.4%)
Number approved but not funded	125 (10.9%)	608 (48.6%)

The total number of research proposals submitted per year has increased slightly from 1986 to 1990. However, because of budget constraints, the number of newly funded proposals (and hence funded investigators) has decreased significantly over the same period. Concurrently, the number of meritorious but unfunded proposals has increased by more than fourfold. This statistic represents a significant amount of important, meritorious research that will not be done. Figure 2 (Page 19) displays graphically this incongruous situation of an increasing number of meritorious proposals and a decreasing proportion of approved proposals being funded.

As discussed above, the involvement of VA physicians in basic and clinical research is essential to maintaining the intellectual environment required for providing high quality health care. To assure physician research opportunities consistent with this principle, the Committee recommends target goals for the number of funded projects in the medical research program as indicated below:

Target Number of Funded New and Competing Projects
in a Year under the Medical Research Program

Merit Review	700
RAGS*	150
Career Development	100

RAGS awards are provided to newly recruited VA clinicians as one or wo year start-up research awards and are based on rigorous peer eview.

To achieve this goal, the Committee recommends FY 1992 funding or the medical research program of $235 million and for the total ealth research program of $280 million.

(2) In addition to continuing to strengthen aging and geriatric esearch, several areas should be targeted for special enhancement as art of the general effort to rebuild the level of VA research to mee ts current needs and for ongoing review by the proposed Health esearch Advisory Council. These include the following:

(a) Development of new research initiatives on mental illness nd substance abuse. As recommended earlier in this report, a well onsidered and coordinated program of Mental Illness Research, ducation and Clinical Care Centers (MIRECCs), supported by adequate rogram development staff, could go a long way in improving the ecruitment and clinical expertise of investigators concentrating on ental illness and addictive disorders.

(b) Expansion of Rehabilitation Research to include ardiovascular, neurologic, psychiatric, and geriatric rehabilitation research to enhance the VA's effectiveness in rehabilitating veterans whose needs are psychosocial or physical rehabilitation while complementing the outstanding investigative efforts already underway in prosthetics and orthotics.

(c) Continued enhanced funding for Health Services Research to improve the VA's organization of services and to address the cost-effectiveness of medical care and the role and value of new technologies. The Committee believes that enhanced investments in outcomes research, clinical epidemiology, and quality assurance studies will ultimately pay off in more effective VA health care delivery and in cost savings.

(3) The Committee strongly recommends a significant increase direct appropriation support to the VA's research program in FY 1992. The Committee was troubled by the analysis of the FY 1991 VA budget request, which mixes direct VA research appropriations with indirect support coming from the medical care budget. Although it is appropriate to use such indirect costs for VA research, these funds cannot substitute for direct research appropriations which allow the purchase of research supplies and equipment and support the hiring of technical research staff. The real reductions in direct funding for the Medical Research Service in FY 1991 are unfortunate and will result in a dramatic decrease in program size and strength, as shown in Table 1 (Page 20). In this connection, the Committee notes with satisfaction the increase in funds allocated for health services research and rehabilitation research and urges continuation of these

trends until funding in these areas becomes commensurate with the nee for research that furthers the provision of high quality care to veterans as advised by the proposed Health Research Advisory Council.

To accommodate these program objectives, the Committee proposes the following budget recommendation for FY 1992:

	($000,000)		
	FY 1990 VA R&D Budget	FY 1991 VA R&D Budget	FY 1992 Committee Recommendatio
Medical Research	$181.7*	$174.1**	$235
Rehabilitation Research	21.7	25.3	28
Health Services Research	9.3	15.3	17
TOTAL	$212.7	$214.7	$280

*In FY 1990, the VA spent an additional $17.5 million transferred from DOD.

**Includes $9 million of DOD funds, originally transferred in FY 1990.

VI. Program Management and Administration

Committee members visited the VA Central Office (VACO) to assess research program management and concluded that, by any current criteria, the staffing of the VA research program is far below acceptable levels. While the small VACO research staff is extraordinarily dedicated and creative in managing its heavy workload, the shortage of competent staff seriously affects the processing of proposals, especially in the Medical Research Service. Considerable expansion is required to assure adequate support for the peer review process. The Committee notes that the 1977 National Academy of

Sciences review recommended VACO research staff expansion at a time when the staff was 300 percent greater than it is today. An initial goal of at least doubling the VACO research staff in one year should be set, with further expansion to take place over a three-year period. Furthermore, based on the projected needs to carry out the proposed Health Research Advisory Council's recommendations for research program enhancement, additional program development staff should be added as necessary.

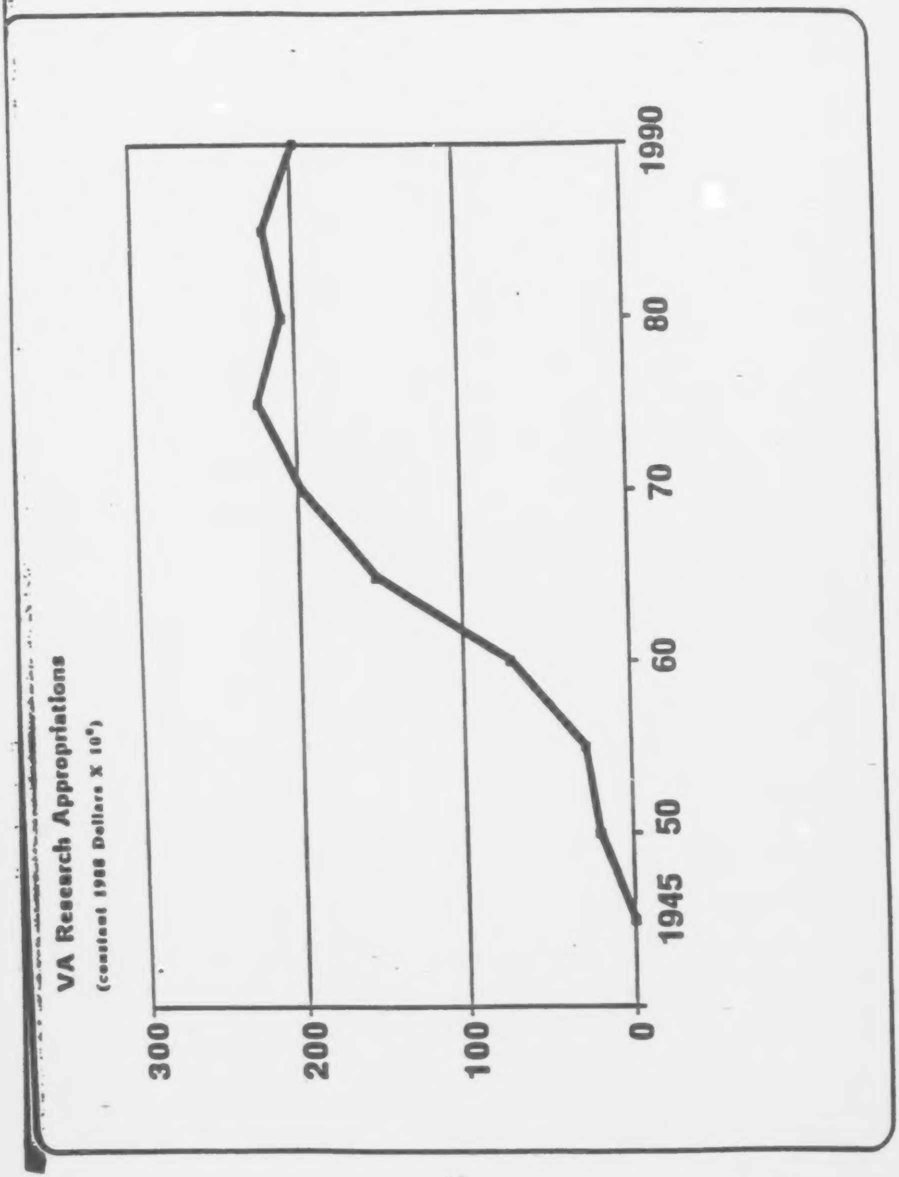
The Committee debated at length the question of whether to recommend reorganizing the VACO research office to add a separate service for mental illness and substance abuse research. While there was considerable support among Committee members for enhancing the VA's research portfolio in these areas, the Committee was not in favor of reorganization of medical research and creation of a new research service. Rather, to maintain maximum administrative and budgetary flexibility and in view of its earlier recommendation to focus on innovative methods for improving recruitment and training of clinicians and researchers in mental illness, the Committee recommends the addition to the VACO research service of scientists who have expertise in mental illness and substance abuse research and who can develop and direct appropriate research initiatives.

CONCLUSION

The VA Advisory Committee for Health Research Policy, after careful examination of all components and activities of the Departman of Veterans Affairs which bear on health research, concludes that thi aspect of Departmental operations is vital to the continued ability o the VA to provide high quality health and medical care to its veteran constituency. The quality of VA-sponsored research in all areas remains high and on a par with health research supported by the NIH and other governmental agencies sponsoring health research. Yet, recent decreases in the financial support of VA research has led to the unwise curtailment of Central Office research staff support for this program, reduced the number of approved projects that can be funded (though there has been a fourfold increase in the number of approved but unfunded projects), and is likely to reduce the attractiveness of VA employment for highly qualified physicians who might be recruited and retained by the system.

In view of these findings, the Committee recommends several concrete steps which, if found feasible and taken over the next year or two, would both restore the long-standing stature of VA research and assure the attractiveness of VA careers for the many clinician-investigators upon whom the VA's high quality of patient care necessarily depends.

Figure 1


VA Research Appropriations
(constant 1988 Dollars X 10^6)
300
200
100
0
1945
50
60
70
80
1990

Merit Review Proposals
1980-1990

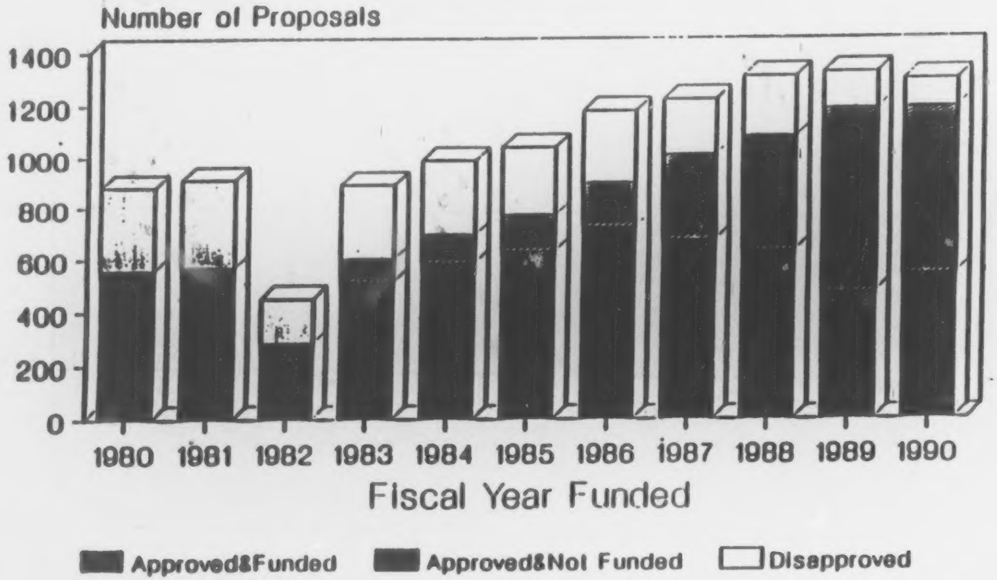


Figure 2

TABLE 1

MEDICAL RESEARCH SERVICE
FUNDED PROGRAMS

FISCAL YEAR	MERIT REVIEW		RAG		CAREER DEV.		TOTAL
	(*)	(**)	(*)	(**)	(*)	(**)	
1984	1664	(586)	207	(152)	185	(88)	2056
1985	1836	(630)	272	(176)	227	(89)	2335
1986	1923	(722)	293	(154)	218	(91)	2434
1987	1907	(672)	224	(157)	221	(91)	2352
1988	1941	(630)	271	(121)	224	(104)	2436
1989	1880	(471)	257	(95)	234	(73)	2371
1990	1762	(542)	220	(100)	240	(53)	2222
1991	1503	(175)	150	(20)	215	(14)	1868

(*) Total number of funded programs in Fiscal Year.
(**) Number of new and competing awards in Fiscal Year.

APPENDIX 1

Advisory Committee for Health Research Policy
Department of Veterans Affairs

Members

Thomas Detre, M.D. (Chairman)
Senior Vice President for Health Sciences
President, University of Pittsburgh Medical Center
3811 O'Hara Street
Pittsburgh, PA 15213

Francois M. Abboud, M.D.
Professor and Head, Department of Internal Medicine
Hospitals and Clinics
University of Iowa College of Medicine
Room SE 308
Iowa City, IA 52242

*Stuart H. Altman, Ph.D.
Dean, The Florence Heller School for Advance Studies
in Social Work
Brandeis University
415 South Street
Waltham, MA 02254-9110

Ernest M. Burgess, M.D.
Director and Principal Investigator
Prosthetic Research Study
720 Broadway
Seattle, WA 98122

Gerard N. Burrow, M.D.
Dean, University of California
San Diego School of Medicine
La Jolla, CA 92093-0602

Paula J. Clayton, M.D.
Chair, Department of Psychiatry
University of Minnesota School of Medicine
420 Delaware Street, SE
Minneapolis, MN 55455

John A. D. Cooper, M.D.
VA Distinguished Physician
4118 N. River Street
Arlington, VA 22207

Michael E. DeBakey, M.D.
Chancellor, Baylor College of Medicine
One Baylor Plaza
Houston, TX 77030

Gordon H. DeFriese, Ph.D.
Professor of Social Medicine
Director, Health Services Research Center
University of North Carolina
Campus Box 7490
Chapel Hill, NC 27599

John W. Goldschmidt, M.D.
Medical Director, Department of Medical Affairs (Retired)
National Rehabilitation Hospital
102 Irving Street, NW
Washington, DC 20010

John W. Kendall, M.D.
Dean, School of Medicine
Oregon Health Sciences University School of Medicine
3181 S.W. Sam Jackson Park Road
Portland, OR 97201

Harry Levitt, M.D.
Speech and Hearing
Graduate School and University Center
City University of New York
33 West 42nd Street
New York, NY 10036

Edward B. Perrin, Ph.D.
Chairman, Department of Health Services
University of Washington School of Public Health
Seattle, WA 98195

David C. Sabiston, Jr., M.D.
Chairman, Department of Surgery
Duke University Medical Center
Box 3704
Durham, NC 27710

Donald M. Steinwachs, Ph.D.
Director, Health Services Research and Development Center
School of Hygiene and Public Health
The Johns Hopkins University
624 North Broadway
Baltimore, MD 21205

Governor Lowell Weicker, Jr.
731 Lake Avenue
Greenwich, CT 06830

T. Franklin Williams, M.D.
Director, National Institute of Aging
National Institutes of Health
Building 31, Room 2C-02
Bethesda, MD 20892

Mr. Rufus H. Wilson
Minority Counsel, House Veterans Affairs Committee
5165 Evangeline Way
Columbia, MD 21044

Staff

Prakash L. Grover, Ph.D. (Executive Secretary)

Robert Arbeit, M.D.
Dennis Ballard
Anna Burns
Karen Harris
Mary Hatfield
Rainelle Holcomb
Ted Lorei
William P. Pare, Ph.D.

*Were able to participate only during the first meeting of the Committee on February 28 - March 1, 1990.

APPENDIX 2

Summary of Activities
of the
Advisory Committee for Health Research Policy
Department of Veterans Affairs

I. Full Committee Meetings

Washington, DC	February 28 - March 1, 1990
Arlington, VA	June 11 - 12, 1990
Pittsburgh, PA	November 16, 1990

II. Task Force Meetings

May 7, 1990	Task Force on "Infrastructure and External Relationships of DVA Research"
May 29, 1990	Task Force on "Special Capabilities and the Quality of DVA Research Program"
May 30, 1990	Task Force on "Research and the DVA Mission"

III. Committee Site Visits to Selected VA Medical Centers

Palo Alto, CA	April 9, 1990
West Los Angeles, CA	April 16, 1990
San Francisco, CA	April 17, 1990
Hines, IL	April 19, 1990
Brockton/West Roxbury, MA	May 14, 1990
Dallas, TX	May 21, 1990
San Antonio, TX	May 22, 1990
VA Central Office, Washington, DC	June 6, 1990

IV. Telephone Interviews with Senior Management of Selected VA Medical Centers Conducted on June 12, 1990

Danville, IL
Knoxville, IA
Togus, ME
Manchester, NH

Lyons, NJ
Canandaigua, NY
Waco, TX
Clarksburg, WV

V. Meetings of Scientific Peer Review Sessions Attended by Committee Members

Surgery	April 7, 1990
Endocrinology	April 16, 1990
Mental Health and Behavioral Studies	April 17, 1990
Neurobiology	April 23, 1990
Oncology	April 23, 1990
Cooperative Studies	April 23, 1990
Career Development	May 3, 1990
VA RAGS Group B	May 4, 1990

VI. Responses to Solicitations of Opinions about VA Research

A. Health Profession Organizations

American Academy of Orthopedic Surgeons
American Academy of Orthotists and Prosthetists
American Association of Colleges of Osteopathic Medicine
American Association of Dental Schools
American Association of University Professors
American Cancer Society
American College of Cardiology
American College of Physicians
American College of Surgeons
American Diabetes Association
American Federation for Clinical Research
American Geriatrics Society
American Lung Association
American Medical Association
American Nurses Association, Inc.
American Psychiatric Association
American Psychological Association
Association for Health Services Research
Association of Academic Health Centers
Association of American Medical Colleges
Association of Schools of Public Health
Endocrine Society
Federation of American Societies of Experimental Biology
Gerontological Society of America
National Alliance for the Mentally Ill
National Association for BioMedical Research
National Council on Alcoholism
Society for Clinical Trials
Society for Neuroscience
Society of University Surgeons

B. Veterans Service Organizations

American Veterans of WWII, Korea and Vietnam (AMVETS)
Catholic War Veterans
Gold Star Wives
Jewish War Veterans
Non-Commissioned Officers Association
Paralyzed Veterans of America
The American Legion
United Spanish War Veterans
Veterans of Foreign Wars
Veterans of World War I
Vietnam Veterans of America

C. Chairpersons, VA Scientific Review Groups

Merit Review Board for Alcoholism and Drug Dependence
Merit Review Board for Basic Sciences
Merit Review Board for Cardiovascular Studies
Merit Review Board for Endocrinology
Merit Review Board for Gastroenterology
Merit Review Board for Infectious Diseases
Merit Review Board for Mental Health and Behavioral Sciences
Merit Review Board for Nephrology
Merit Review Board for Neurobiology
Merit Review Board for Oncology
Merit Review Board for Respiration
Merit Review Board for Surgery
Scientific Review and Evaluation Board (HSR&D)
Scientific Review and Evaluation Board (RR&D)
--Communications, Sensory and Cognitive Aids Panel (Vision)
--Communications, Sensory and Cognitive Aids Panel (Speech and Hearing)
Career Development Committee

D. Institutes of NIH

National Cancer Institute
National Center for Nursing Research
National Eye Institute
National Heart, Lung, and Blood Institute
National Institute of Allergy and Infectious Diseases
National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute of Dental Research
National Institute of Environmental Health Sciences

GROUPS ENDORSING FY-92 PROPOSAL OF FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH

(February 20, 1991)

American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Neurology
American Academy of Otolaryngology Head & Neck Surgery, Inc.
American Association of Dental Schools
American Association of Colleges of Osteopathic Medicine
American College of Physicians
American College of Rheumatology
American College of Cardiology
American Dental Hygienists' Association
American Diabetes Association
American Federation for Clinical Research
American Gastroenterological Association
American Geriatrics Society
American Heart Association
American Lung Association
American Optometric Association
American Physiological Society
American Psychiatric Association
American Society of Hematology
American Society for Clinical Pharmacology and Therapeutics
American Society for Biochemistry
American Societies for Gastrointestinal Endoscopy
Association of Academic Health Centers
Association of American Medical Colleges
Association of Anatomy Chairmen
Association of Independent Research Institutes
Association of Professors of Dermatology, Inc.
Citizens for Public Action on Blood Pressure and Cholesterol, Inc.
National Alliance for the Mentally Ill
Nurses Organization of Veterans Affairs
Research!America
Society for Investigative Dermatology
The Epilepsy Foundation of America

FRIENDS OF VA MEDICAL
CARE AND HEALTH RESEARCH

A PROPOSAL FOR
FY 1992

Executive Summary

Successive years of unmet financial needs have left the Department of Veterans Affairs (VA) health care system facing serious problems in 1991. The result is a system where patient care services are beginning to suffer, and opportunities for research breakthroughs are being lost. In order to correct for the mistakes of the past and provide for the needs of the future, the Friends of VA Medical Care and Health Research (FOVA) make the following recommendations for fiscal year (FY) 1992.

Medical Care

FY 1990 Actual	FY 1991 Actual	FY 1992 Administration Request	FY 1992 FOVA Recommendation
$11.43B	$12.31B	$13.28B	$14.89B

Our recommendation for medical care for FY 1992 is based on a current services budget for FY 1991 of $14.02 billion, with enhancements for such activities as extended care for elder veterans, the replacement of obsolete equipment, treating post-traumatic stress disorder, and providing long-term psychiatric care. Once again, the FOVA join with the veteran service organizations' Independent Budget in making our medical care appropriations recommendation, which would enable the VA to provide high quality medical care services to all eligible veterans.

Health Research

FY 1990 Actual	FY 1991 Actual	FY 1992 Administration Request	FY 1992 FOVA Recommendation
$212.6M	$216.8M	$216.8M	$281.0M

The FY 1992 Friends of VA recommendation would return the research program to its FY 1985 level of effort -- the last year before the effects of sequester and budgetary cutbacks were felt in the program. The recommendation is identical to that called for the VA Secretary's Advisory Committee for VA Health Research Policy. While the needs of the program dictate that $281 million be provided in FY 1992, the Friends of VA have the goal of achieving this level of effort by FY 1995.

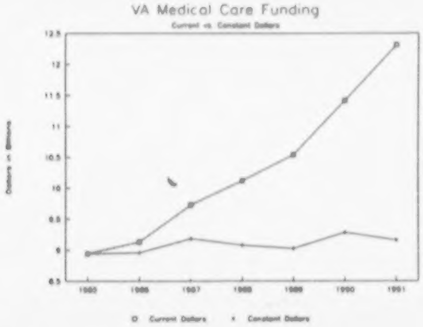
(See Appendix for Details on Recommendations)

For more information call
(202) 828-0525
or write
Friends of VA Medical Care and Health Research
1 Dupont Circle, NW, Suite 200
Washington, DC 20036

MEDICAL CARE

The Department of Veterans Affairs (VA) currently operates America's largest comprehensive health care delivery system, providing care to over 13 million patients at 500 facilities across the country. The VA carries out its medical care mission through inpatient, outpatient and long term care facilities, and through affiliations with medical, dental, and other health professions schools.

The VA medical care program's goal is to provide the highest quality services to VA patients. In recent years, however, the VA has seen a steady decline in its ability to fulfil its quality care mission, and to provide necessary care to all those who are eligible. This situation is a direct result of the 'flat-line' funding of the VA medical care appropriation throughout the 1980s. At a time when VA patients are aging rapidly (as early as 1995, one-third of all veterans will be over 65) and requiring more medical care services for a longer duration, VA medical care funding has remained stagnant when adjusted for inflation.



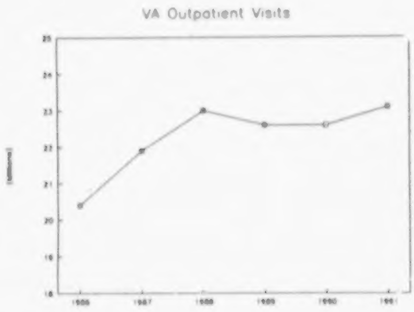
Increased resources for direct patient care services, the replacement of outdated equipment, and the recruitment and retention of health professionals of all types, particularly physicians, nurses, and other allied health professionals are needed immediately. The current lack of funding has fostered a decline in satisfaction and trust in the system among VA patients, and a weakening of morale among VA staff.

For FY 1991, Congress appropriated $12.3 billion for VA medical care, an increase of nearly $1 billion from the previous fiscal year. This increase was helpful, but still insufficient to meet the needs of the VA health care system and its veteran patients. Right now, VA Medical Centers and other facilities are closing beds, not replacing outmoded equipment, delaying surgical procedures, and leaving critical staff positions unfilled.

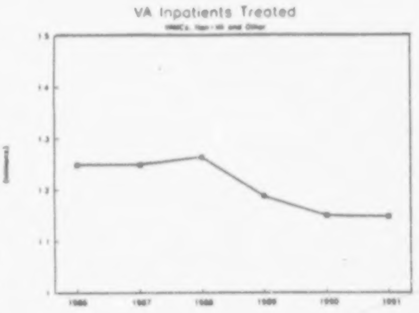
The last five years have seen a marked shift in VA workload activity. As illustrated below, fewer veterans are receiving care on an inpatient basis, and an increasing number are receiving services from VA clinics and other outpatient facilities. It must be kept in mind that while the move from the hospital to the outpatient setting is reflective of changes taking place throughout our national healthcare delivery system, it has occurred at the same time as the static VA medical care budget, as shown in the graph above.

Page 2

Thus, concern must be given to the impact of this flat-line budgeting on limiting access to care.



VA Outpatient Visits



VA Inpatients Treated

Recommendations for appropriations for FY 1992 must include an adjustment for the previous lack of resources. To forgo such an adjustment would perpetuate the damage caused by past underfunding. Taking into account such items as general inflation, payroll adjustments, AIDS care, and facilities activations, the FY 1991 appropriated level of $12.31 requires an upward adjustment of $1.71 billion to reach the FY 1992 current service level of $14.02 billion.

For FY 1992, the Friends of VA recommend a total medical care appropriation of $14.69 billion. Funding at this level, which is the same as that recommended by the VSO Independent Budget, is an increase of $2.58 billion over the FY 1991 appropriation and $870 million over the current service level. Included in the Friends of VA recommendation are the following system enhancements:

Expanded Geriatric Care. Both the Geriatric Evaluations and Management Units (GEMs) and the Geriatric Research, Education and Clinical Centers (GRECCs) should be expanded to care for the increasingly elderly veteran population. Data indicates that the GEMs are self-financing as they reduce the need for patient institutionalization. Expanding the GRECCs from 12 to 16 will help the VA retain its leadership in research and care for the elderly, while at the same time controlling costs. An increase of $3 million in FY 1992 should cover this expansion.

AIDS. The VA cared for over 6 percent of the nation's AIDS cases, or 11,280 patients in 1992, including over 3,000 new admissions. Additional funding urgently needed to cover this expanded workload, so that the VA will not have to transfer funds from other medical care accounts for AIDS patients. The Friends of VA recommends $52.5 million in additional funding for AIDS in FY 1992.

Equipment. The scarcity of new equipment in VA medical centers has raised concern about the impact of outmoded equipment on the quality of patient care services. The longer the VA delays the purchase of up-to-date equipment, the farther it will fall behind the rapid advance of medical technology. In order to modernize VHSRA's equipment, the Friends of VA recommend the appropriation of an additional $100 million in FY 1992.

Education and Training. The affiliation agreements between the VA and medical, dental and other health professions schools are a vital component of the VA health care system. The VA's academic partners help recruit and retain highly qualified health professionals, and alleviate staffing shortages. The Friends of VA recommends an additional $26.5 million for expanded education and training efforts, including increasing numbers of residents and fellows in high demand specialties, expansion of the VA health professions scholarship to medical students, and strengthening the continuing education of service chiefs and other key health care personnel.

Mental Illness Research, Education and Clinical Centers. Authorization for the establishment of five of these units was included in last year's Senate omnibus veterans bill (S. 2100). Like their geriatrics counterparts, the MIRECCs attempt in integrate emerging research findings into clinical care. $6 million should be appropriated in FY 1992.

HEALTH RESEARCH

The quality of the VA's medical care services would not be as high were it not for the VA's health research program. VA-funded research in the areas of medical, health services, and prosthetics, have led to discoveries benefiting VA patients and the population at-large, the development of cost-effective treatments, and the improvement of the VA's ability to recruit and retain highly qualified health professionals.

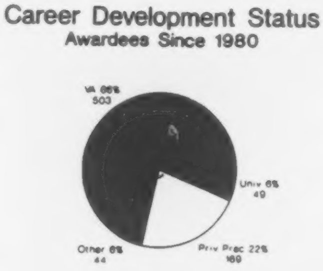
Questions have been raised about why the VA does research at all, given that the National Institutes of Health and other federal agencies spend over $10 billion annually on such projects. In addition to a significant impact on the recruitment and retention of physicians, the VA program produces research of high quality and knowledge of importance to the advancement of science. A short, and by no means exhaustive, list of these discoveries include:

- A means of treating of high blood pressure with significantly lower levels of medication, reducing both the toxic side-effects caused by many anti-hypertensive agents, as well costs to the VA of purchasing the drugs.
- The development of a computer-based analysis system that can diagnose lower back muscle disfunction, leading to a prescribed therapeutic exercise regimen in place of surgery, for treatment of chronic back pain.
- The successful evaluation of implantable insulin pumps in diabetic patients. The wide-spread use of such devices could eliminate the need for daily injections for many with diabetes.

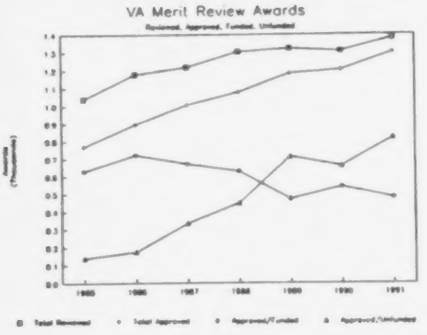
The VA attracts a substantial number of clinical investigators -- physicians dedicated to both patient care and research -- who attack those medical conditions of greatest relevance to the veteran population, and apply the results of this research to direct care of VA patients.

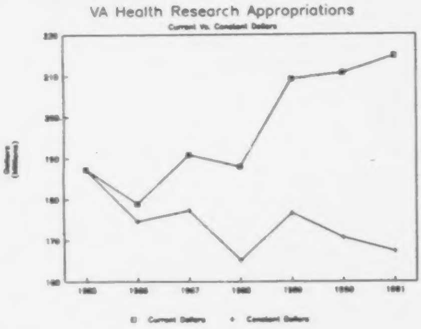
The research program has also been a very important tool in retaining high quality physicians within the

VA. As the chart below indicates, of those investigators that have received VA Career Development awards (long-term research grants for promising young investigators) between 1980 and 1989, two-thirds stayed within the VA system.



Clearly, the VA funds quality research. Unfortunately, despite these ground-breaking discoveries and the positive impact on physician recruitment and morale, financial support for VA research has been lacking. The two charts below are illustrative of this fact: over 80 percent of the applications submitted are approved for funding; yet, less than 40 percent of those approved are eventually awarded. At the same time, appropriations for medical research have declined in real terms by over $20 million since FY 1985. The decline in funding parallels the decline in numbers of awards.





FY 1992 is no exception to this damaging cycle: the President's budget includes $216 million for VA research, ***the same level as the current fiscal year!***

The Administration's lack of support is particularly disheartening given the recent recommendations of the VA Secretary's Advisory Committee on Health Research Policy. This group, known as the "Blue Ribbon Commission" was established to examine the current state of the VA research enterprise, and make recommendations for the future of the program.

Overall, the Blue Ribbon Commission concluded that the VA research program is essential to providing the best care for VA patients, and functions as a vital component of both the VA system and our national research effort. In spite of this, the Commission judged that the program has been significantly underfunded each year since 1985. The Commission concluded that the program needs to regain its FY 1985 level of effort, translating in their calculation to an FY 1992 appropriation of $281 million.

The Friends of VA wholeheartedly support the Blue Ribbon Commission's assessment that the research program should return to its FY 1985 level of effort -- the coalition has made this identical argument for the past three years. We also share in the Commission's belief that the research program requires an appropriation of $281 million for FY 1992. However, given the limitations placed on domestic spending, as well as the need for overall fiscal prudentcy, the Friends of VA recommend that the Blue Ribbon Commission's goals be achieved by FY 1995.

An FY 1992 appropriation of $280 million would support approximately 1,840 investigator-initiated research projects, 227 career development awards, and 26 cooperative studies -- all the same number as was funded by the VA in FY 1985. The Health Services and Rehabilitation research services would be funded at levels $17 and $28 million, respectively. An additional $9.7 million would be slated for special research initiatives of critical need such as AIDS, nerve regeneration, and drug abuse. The Friends of VA believe funding at this level will revitalize the research program overall, and lead to further advances against those conditions which most often afflict the veteran population.

APPENDIX – RECOMMENDATIONS FOR FY 1992

	Medical Care
FY 1991 Appropriation	$12,310,490
FY 1991 Current Services	$12,919,600
FY 1992 Current Services Adjustments	
Payroll Related Increases	546,000
Inflation	250,000
Facility Activations	50,000
Adjustment to Program Base	120,000
AIDS	52,500
Special Pay	50,000
Miscellaneous - Other	32,500
Total	1,101,000
FY 1992 Current Services	14,020,600
FOVA Initiatives for 1992	
Outpatient Workload Increase	$ 215,000
Extended Care	364,000
Homeless Program	5,000
Post-Traumatic Stress Disorder	7,250
Long-Term Psychiatric Care	1,000
Blind Vet. Rehabilitation	1,500
Prosthetic & Sensory Aids	4,000
Education & Training	157,000
Decentralized Hosp. Computer	
Program	14,500
Equipment	100,000
FOVA FY 1992 RECOMMENDATION	**$14,889,850**

	Health Research
FY 1991 Appropriation	$ 216,000
FOVA Initiatives For FY 1992	
Medical Research	234,500
Rehabilitation Research	28,000
Health Services Research	17,000
Agent Orange Research	1,000
FOVA FY 1992 RECOMMENDATION	**$ 281,000**

TESTIMONY OF DANIEL H. WINSHIP, M.D., DEAN
LOYOLA UNIVERSITY CHICAGO, STRITCH SCHOOL OF MEDICINE
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES, CONGRESS OF THE UNITED STATES
CONCERNING THE DEPARTMENT OF VETERANS AFFAIRS FISCAL YEAR 1992 BUDGET
FEBRUARY 21, 1991

Mr. Chairman and members of the committee, I appreciate the opportunity to appear here today to give testimony concerning the Department of Veterans Affairs Fiscal Year 1992 Medical Programs Budget. My recent experience of responsibility for programs and operations of the Veterans Health Service and Research Administration coupled with my current position as Dean of a medical school highly affiliated with Hines VA Medical Center, a large tertiary care VA medical center in Chicago, I believe provides me with an important perspective with which to view this budget. The $976 million, almost $1 billion, is a sizable increase in the VA health care budget. If those funds were to provide for current services plus begin to repair the erosion of the last decade or more of the VA health care purchasing power, this would be a very positive step. Unfortunately that is not the case. Simple arithmetic shows that of the $976 million, fully $860 million will be initially committed to fund inflationary expenses of personnel and all other costs; the remaining approximately $116 million will fall far short of the VA's needs for even holding its own in its health care activities. The budget fails to deal with some exceptional but unavoidable increases, such as pharmacy costs, which will far exceed the estimated 6% inflationary factor presented. So once again, the overall funding level will result in a further erosion of an already inadequate budget before any real attention can be paid to the repair of a cronically decimated infrastructure or to deal with implementation of important initiatives. In fact, I suspect that many of the initiatives that have been identified will not be carried out with this budget in 1992 because the estimates are so far short of what will actually be required.

I have comments on several specific items in the budget. First, the management initiative of the workload shift from hospital to outpatient care with its attendant reduction in 1,178 FTE and $70 million. I predict this will not occur. Operationally, the reduction in FTE and funds will not simply shift workload from inpatient to outpatient delivery but will, in fact, reduce many inpatient programs beyond their ability to survive and simply will not be accomplished. Little shift will therefore take place, especially without increased resources provided to already over-stressed outpatient services. Here lies a good opportunity to help the future of VA health care by adding resources to the outpatient services to allow the inpatient services to use their resources to better advantage.

Nursing home bed conversions are an admirable goal, but the flaw in the rationale as presented is that these are in the main idle, unstaffed beds. Therefore, shifting resources to staff the unstaffed beds will result, again, in a decreased inpatient capability with the same result as just discussed. I would predict that this initiative will not be implemented with this budget.

I applaud the adoption of Medicare rates as payment in full for private physicians who treat veterans. If the estimated savings are at $25 million for the first year, however, why then reduce the budget by $35 million? This reduction can be predicted to result in a further $10 million erosion of the health care budget. Even that assumes that the VA can get these rates fully implemented in this time frame. If they do, fine, but my expectation is that it will take longer to be able to meet the anticipated income level from Medicare.

Current political climate regarding resident work limits in the country make a request of $100 million to deal with this situation very realistic and appropriate indeed. I would urge, however, the VA be free to distribute these funds among FTE to solve the variety of problems which will be encountered rather than to dictate prospectively, without experience, what specifically must be done with the funds.

The increase in funding of replacement equipment by $52 million is a positive step. The problem, of course, is that even this sum is far less than that which is needed. I doubt seriously that this level of funding will keep up with the growth of the replacement equipment backlog. Last year the backlog was $650 million and I understand it has currently grown to some $750 million this year. I predict it will continue to out-strip the budget. Specific attention should be paid to this item because it is one of the most important budget issues in the entire health care program which deals directly with the ability of the VA to maintain quality care and where erosion translates directly into eroding quality of care.

Similarly, the non-recurring maintenance increase is an important step which I applaud. I hope that it is adequate to help reduce the dependence of the VA on its facilities for its ability to meet its budgetary shortfalls. Continued attention to this very important budgetary item is warranted.

The transfer of the Medical Cost Recovery administration is a wonderful example of the kind of convoluted, flawed thinking which has resulted in the fiscal problems of the VA over the last decade or more. The VA was mandated to develop and then expand the MCCR program, but with no resources accompanying the mandate to perform the task. So VHS&RA did it, carving the required personnel and other resources out of existing, already stressed programs to perform the job. The result was that the effort was well-launched with assignment of appropriate personnel, while the services they had been providing were left limping even more. So now the budget proposal calls for removing those FTE and their supporting funds from VHS&RA to a new account, outside of medical care. Reason and equity would demand that they be placed back where they came from and that new positions for the new task be created and paid for out of the collections. To do otherwise seems totally irrational to me.

The marked reduction in beneficiary travel is probably justified in lean budget times, but compassionate law makers should remember that the vast majority of the VA's constituency is indigent, many of whom have little if any ability to travel any real distance to obtain their medical care.

The discussion and request concerning activations is hard for me to understand. To add a net of 1,285 FTE but with a net reduction of $28 million in the program appears to me to guarantee continued poor activation performance. The Department of Veterans Affairs has had a number of embarrassments in this area in recent years and this kind of budgeting would appear to me to ensure continuation of those embarrassing situations.

There probably is no more important piece of the budget for the welfare of VHS&RA than the $200 million plus which goes to research. The fact that this budget has been straight-lined (or worse) for several years has resulted in a reduction in numbers of investigations, in good grants not being funded, in good people leaving, in the research service trying to survive with obsolete equipment, in inability to compete, etc. I trust that Secretary Derwinski meant what he said as he established the blue ribbon panel on VA research when he indicated that he would follow their recommendations. It is my understanding that they strongly recommended that sufficient funds to repair the research service be added to the budget before it is too late. I also understand that the Department of Veterans Affairs actually did make that request but the Office of Management and budget did not heed it. I urge you to pay particular attention to restoration of this account to a status of fiscal health over the next 1-3 years.

The continued reduction of the MAMOE account is totally incomprehensible to me. To reduce the staffing of VHS&RA Central Office activities by one-half over the last 5 or 6 years while complexity, number of programs, amount of congressional and other requirements have grown enormously seems completely unrealistic and dysfunctional. If the budget must be reduced (and it is such a small portion of the overall budget I cannot imagine that it must be) then specific statutory relief to permit the required work of the Central office to be done elsewhere within VHS&RA, specifically in various field offices, must be pursued. To do less will result in further crippling of the ability of VHS&RA to even begin to approach reasonable management of its administrative workload.

Thank you once more for the opportunity to comment on this proposed budget. I am prepared to answer any questions you may have.

LOYOLA
UNIVERSITY
CHICAGO

STRITCH SCHOOL OF MEDICINE
Office of the Dean

2160 South First Avenue
Maywood, Illinois 60153
Telephone (708) 216-3223

March 14, 1991

The Honorable Joseph Kennedy
House Veterans Affairs Committee
335 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Kennedy:

In the hearing of the House Committee on Veterans Affairs concerning the Department of Veterans Affairs Fiscal Year 1992 Budget, on February 21, 1991, you requested that I submit, for the record, some specific cases that I had outlined from the memo I had received from Dr. William Best, Chief of Staff of the Hines VA Medical Center in Chicago, concerning the effects of VA budgets on VA health care functions during the past decade or so. I am happy to mention a number of medical situations which serve as examples of the inability of the Hines VA Medical Center to provide the kind of medical care the staff believes it should. State-of-the-art health care includes a variety of newer, frequently high-tech diagnostic modalities, such as computerized tomography, magnetic resonance imaging, nuclear medicine imaging, positron emission tomography, flexible endoscopy, ultrasound imaging and others. Many of these modalities should be expanded to hospitals that do not have them; failure to accomplish that results in those hospitals turning to medical centers such as Hines to provide them. Hines is at capacity in providing CTs and MRIs. Some patients who would benefit from them are passed by because they are considered "too low a priority". Positron emission tomography (PET), a special area in nuclear medicine, is just coming into its own and is not even available at Hines or in any Chicago VA.

In my testimony I mentioned the difficulty in maintaining organ transplant patients with cyclosporin because of the drug's high cost. The cost of maintaining a patient post-transplant has forced the Hines VA Medical Center to turn away patients who were not transplanted by Hines because Hines does not have the funds to supply the drug. The patient is caught in the middle. Of many newer and sophisticated therapeutic techniques such as coronary angioplasty, extracorporeal shock wave lithotripsy, endoscopic treatment, electrophysiologic treatment via cardiac catheterization, funding modulates how many of these proccedures can be done and they are limited to only the highest priority patients because of their cost.

In artificial part replacement, such as lens replacement in patients with cataracts, hip or knee replacement, implantation of artificial pacemakers or automatic defibrillators, implantable devices for deafness, the VA has the easiest job in rationing care because many of these procedures are not of an emergent nature so the VA can simply have patients wait. Long waiting lists therefore develop which means that patients suffer interminably or else they give up on the VA and get help elsewhere, frequently through their Medicare funding.

Coronary artery bypass surgery deserves special attention. Problems in funding and in the compensation the VA can offer highly trained professionals has kept the number of procedures performed well below the need in the Hines VA patient population. Some patients die awaiting a surgery date; others go to the private sector and have their procedure done under Medicare.

In my testimony I mentioned erythropoietin, a wonderful new drug which can prevent the need for multiple transfusions in patients on dialysis with end stage renal failure. The Hines VA Medical Center rations how much it gives each patient as well as how many patients can receive it because of funding problems.

In sum, given more patients than can currently be provided high quality health care under the Hines VA Medical Center budget, the options of the staff there are as follows:

A) Improve efficiency in providing health care,
B) Reduce the amount of care given,
C) Reduce the quality of care given,
D) Increase the funding, or
E) Some combination of A through D.

A decade and a half of budget erosion has greatly reduced the potential for pay-off under A. We simply cannot tolerate C. If D does not occur then we are left largely with B. Hines is a wonderful, high-quality VA medical center. It is painful to observe it in its inability to meet the demands placed on it.

Thank you for your interest. I hope these comments are of help to you. If there is any other information I can provide you, please do not hesitate to call on me.

Sincerely,

Daniel H. Winship

Daniel H. Winship, M.D.
Dean

DHW:dw

STATEMENT OF JOHN HANSON, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 21, 1991

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to set forth its views on the proposed funding for programs and operations of the Department of Veterans Affairs for Fiscal Year 1992, following an initial appraisal of the budget submitted to Congress by the Administration.

This budget provides $17 billion for benefit programs, $13.4 billion for medical care programs, and $592.5 million for medical construction. Total full-time equivalent employment (FTEE) for the Department of Veterans Affairs will be funded at a level of 224,877 FTEE, which represents an increase of 948 FTEE over the FY 1991 staffing level.

On the surface, the proposed funding level for FY 1992 appears to provide a substantial increase over FY 1991. VA's proposed medical care budget for FY 1992 is $974 million above the current year budget estimate. This represents the second consecutive year of a medical care budget increase request of close to $1 billion. It is important to note that the proposed medical care funding increase will be largely taken up by pay increases and inflation. The funds requested still fall short of the $14.3 billion The American Legion requested for FY 1992.

While the proposal includes some positive points, there are also a number of what we consider to be ill-considered assumptions and proposals incorporated into the structure of this budget, and in the course of this statement we will address each of these in detail.

Mr. Chairman, we believe it is necessary to reiterate The American Legion's longstanding position on funding of veterans benefits and programs.

The American Legion has a total commitment to the health and well-being of this nation's veterans dating back to its founding in 1919, and therefore, stands for full funding for veterans programs. By that we mean that there should be sufficient funds for VA to carry out each of the programs established by Congress. The American Legion supports all of these programs. Each of them had a purpose when enacted, and we believe each has proven currently to be meeting a legitimate need of the veteran population.

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

In September 1990, The American Legion presented its legislative agenda for the first session of the 102nd Congress before a joint meeting of the House and Senate Veterans Affairs Committees. At that time, we recommended a funding level of $14.3 billion for VA medical care for FY 1992. Today, we strongly believe VA health care must be funded at the recommended level of $14.3 billion in the upcoming budget year.

The Administration's proposed medical care funding level of $13.3 billion for FY 1992, is a positive development, considering the discretionary spending caps agreed to in the Budget Reconciliation Act of 1990. The proposed increase of $976.6 million for veterans medical care in FY 1992, above the current service level, marks the second consecutive year in which the VA health care system would receive a budgetary increase of close to $1 billion. Additional funding in this amount each year over the next several years would be deemed adequate to continue the provision of quality care. While an increase of close to $2 billion over two successive budget years is commendable, it must be pointed out that this funding increase only permits VA to recoup some of the funding losses incurred during the 1980's.

In nominal terms, appropriated dollars for VA medical care have increased by $6.5 billion, from $5.8 billion in FY 1980 to $12.3 billion in FY 1991. In constant dollars, however, funding has increased by only $600 million. This represents only a 10.3% increase during an eleven year period, or less than one percent per year during a time when the medical consumer price index was in double digits.

As a result of successive decremental federal budgeting for VA health care over the last decade, significant restrictions in veterans health care eligibility have occurred throughout the VA system, specifically in the past two years. The current emphasis in VA health care centers is on providing quality service to the entitled veteran workload, across a broad spectrum of programs. There is a suppressed workload demand which will continue to increase among poor and elderly nonservice-connected veterans. This veteran population will be unable to obtain VA health care services due to inadequate appropriated resources. They generally have insufficient family support systems and little or no health insurance coverage. It is these veterans who, in the past, have relied on the VA health care delivery system as a last safety net. This situation is further complicated by separate eligibility rules and regulations for inpatient and outpatient care for the mandatory workload population. Some veterans who are eligible for acute inpatient care are not eligible for a continuum of outpatient or long-term care. This incongruity particularly impacts the aging veteran population and also disrupts care for other veterans.

Given the static level of resources within the VA health care system, both eligibility and the range of available services are no longer needs driven but are unmitigatingly resource driven.

Recent trends reflect a continuing reduction in VA health care services across all categories of care, except domiciliary services. From FY 1988 thru FY 1990, the total number of inpatient discharges show a decrease of 9.4%. Within this category, psychiatric patients treated decreased 12.0%; surgical patients treated decreased 10.7%; and medical patients treated decreased 7.8%. During the same period of time, VA nursing home patients treated decreased 0.6%; community nursing home patients treated decreased 46.4%; and VA staff outpatient visits decreased 0.4%.

The American Legion believes the recent changes in veteran eligibility criteria brought about by the Budget Reconciliation Act of 1990 which replaces Categories A, B and C with mandatory and discretionary care eligibility categories, will lead to further patient care reductions. We fear these changes will encourage VA medical facilities to concentrate their resources on the provision of care to the mandatory veteran population, while services for the discretionary care veteran will only be possible for emergent conditions.

Mr. Chairman, medical and hospital services for veterans represent one of the most far-reaching benefits bestowed by a grateful nation on its defenders. Whether it be for service provided in wartime or during peacetime, the veterans of this country have endured many hardships and sacrifices and, in our view, have already paid the price for benefits to be received. The American Legion believes all honorably discharged veterans have earned post-military medical benefits, particularly sick and aged veterans who come from the ranks of the poor and indigent, and those without private health insurance. Mr. Chairman, just as the veterans answered the call of their nation in a time of need, so too must the government of the United States provide assistance to veterans in their greatest hour of need.

Delegates to The American Legion's 92nd National Convention in Indianapolis, Indiana, approved Resolution No. 392, which mandates this organization to urge the Congress and the President to provide sufficient funding to enable the Department of Veterans Affairs to utilize all modalities available in the health care field, and to assure available care for the maximum number of veterans who need and apply for such care.

Resolution No. 392 also expressed the Legion's belief that the medical benefits provided by law to veterans are in fulfillment of a sacred obligation of the nation to its defenders. We urge the Congress to assign the highest budgetary priority to the provision of funds for the administration and delivery of veterans medical care benefits.

The proposed FY 1992 budget request of $13.3 billion for veterans medical care will permit a workload level of 1,150,890 inpatients treated and 23,571,000 outpatient visits (combined staff and fee outpatient medical visits). These totals represent an increase of 4,390 inpatients treated and 500,000 outpatient visits above the projected FY 1991 workload levels. Of the $976.6 million increase in net obligations proposed for veterans medical care in FY 1992, payroll increases of $581.3 million and increased inflation costs of $279.5 million (including rate changes in State Home programs) absorb a majority of the proposed funding increase. New program initiatives account for a net increase of $144.3 million. Also, an increase of 1,476 full-time employee equivalent (FTEE) positions are recommended. However, in regard to the FTEE increase, a majority of these positions will be offset by an anticipated resident work limit initiative. $292.2 million is budgeted for facility activations in FY 1992 and 2,009 FTEE. Part of these funds represent a carryover from FY 1991 resources. The proposed 2,009 FTEE total for FY 1992 facility activations is already projected to be reduced by 724 FTEE due to required staffing re-estimates.

There are positive features included in the Administration's FY 1992 medical care budget proposal. With regard to certain program initiatives, The American Legion views favorably the Automated Data Processing funding request to support medical programs. We also support management initiatives to continue strong oversight of VA hospital programs resulting in increased efficiency and economy. Program initiatives to shift workload from hospital to outpatient care settings, where medically feasible, are appropriate and consistent with management efficiency. Other initiatives include converting under-utilized hospital beds to nursing home care beds, expanding drug abuse treatment and AIDS treatment, unit dose dispensing, and adding one new Geriatric Research, Education, and Clinical Center (GRECC) to increase the basic knowledge on the aging process. It is also wise, as proposed, to increase the nonrecurring maintenance and repair program by $92.3 million for FY 1992, so that VA can meet renovation and repair requirements.

Mr. Chairman, we remain concerned about the dollar value of the burgeoning backlog of VA's equipment procurement requirements. Currently, the replacement and additional equipment backlog is estimated by VA officials to be approximately $1.2 billion. For FY 1992, a total of $400 million is proposed for the equipment capital investment program. Of this amount, replacement equipment for existing facilities totals $122.5 million and $32.7 million is proposed for new construction projects. For additional equipment $242.6 million is proposed, including $78 million for existing facilities, $131.4 million for new construction projects, and $31 million for education and training, and special computerization projects. The American Legion recommends doubling the proposed $400 million equipment budget for FY 1992. Without an immediate substantial increase in this capital investment program, VA will always lag behind in meeting its technological requirements.

In summary, a proposed increase of $976.6 million for VA medical care for FY 1992, will help meet the goal of providing quality medical care second to none. The American Legion believes its recommendation set forth in September 1990 for a FY 1992 medical care budget of $14.3 billion is valid and modest. An increase of $1 billion above the Administration's proposed medical care budget for FY 1992, will provide a better base of operations for necessary supplies and pharmaceuticals, facility activations, reduce long appointment waiting times, develop additional new program initiatives, enable VA to reduce its equipment backlog, and provide a larger safety net for those veterans who have no where else to turn than VA, when in need of necessary medical care.

MEDICAL AND PROSTHETIC RESEARCH

The Department of Veterans Affairs Medical and Prosthetic Research Program is a matter of particular interest to The American Legion, as a result of our sensitivity to the importance of research in the triad of VA health care programs: clinical care, education of health manpower, and research. These three functions cannot thrive independently - the presence of each is required. It would be impossible for VA to continue to provide high quality medical care without a strongly funded research program. As this Committee knows, much of the research in which VA engages is applied research which is advantageous not only to the mission of VA, but is of direct benefit to all mankind. Equally important is the premise that a strong research program ensures the recruitment and retention of high quality physicians into VA service. We believe the federal government could make no wiser investment than ensuring a vigorous and viable VA research program.

The FY 1992 VA Medical and Prosthetic Research funding request represents a straight line budget at the same FY 1991 budget level of $216.8 million. Of the three main budget research accounts, medical research, rehabilitation research, and health services research, the medical research program will witness a second consecutive year of zero budget growth. Even though the rehabilitation research program and the health services research program are recommended to be funded in FY 1992 at the same level of budget authority as in FY 1991, both of these programs realized significant budgetary increases during FY 1991. Thus, while all three programs will realize real dollar funding decreases in the Administration's FY 1992 budget proposal, medical research will suffer a greater decline in budget authority.

The American Legion strongly objects to the Administration's Medical and Prosthetic Research funding proposal for FY 1992. We must ask, is VA no longer committed to conducting cutting edge research? Does a budget proposal which is set at previous year levels represent a vote of no confidence in VA research activities? The American Legion certainly hopes the answers to these questions are, unequivocally, no.

Mr. Chairman, personnel and "all other" cost increases, inevitably sustained from year to year, as well as recently approved geographic personnel cost increases, are not provided for in the Administration's FY 1992 research budget proposal. At a time when other federal research programs are recommending a budget increase of 9.5% for FY 1992, keeping VA research programs at their current budget estimates will not substantially help balance the federal budget. When roughly 75% of VA research costs are personnel services related, approximately 348 FTEE will be lost in medical research activities. When people are eliminated, research projects have to be reduced. In FY 1991, VA medical research approved the lowest number of merit review projects since FY 1985. Of 1,200 approved research projects, approximately 480 were approved during FY 1991. During FY 1992, this total will be further reduced.

Mr. Chairman, to illustrate the declining purchasing power of medical research funding, from FY 1985 to the Administration's proposed FY 1992 medical research budget level, the constant funding dollar level has risen from $165 million to $176 million. Concurrently, the real dollar funding level has decreased from the FY 1985 level of $165 million to the current estimated level of $130 million.

VA Medical and Prosthetic Research funding level must be sufficient to support VA's patient care mission. Over the past several years, Department of Defense (DoD) research funds have helped support VA research programs and helped VA prevent massive cutbacks. Unfortunately, we believe the FY 1992 budget proposal for VA related research activities represents a serious error in judgment.

An internationally respected panel of researchers completed and submitted to VA the results of its Blue Ribbon Research Commission Review of VA research programs in January, 1991. This prestigious panel of researchers recommended that VA research activities be funded at a level of $280 million during FY 1992. Further, the majority of the recommended increase was suggested to be applied toward medical research programs. The panel also suggested increasing rehabilitation research and health services research activities for FY 1992.

The American Legion believes the Administration's proposed FY 1992 VA Medical and Prosthetic Research budget proposal of $216.8 million, plus the DoD add-on of $10 million will seriously impair VA research programs for years to come. The combined recommended funding level for FY 1992 of $226.8 million will not contribute to attracting and retaining high quality medical researchers. Adding the $35 million of eroded purchasing power for medical research programs from FY 1985 to the proposed FY 1992 funding level would, when added to the proposed FY 1992 combined level of $226.8 million, bring research funding to $261.8 million. The balance of the difference between the $280 million recommended for FY 1992 by the Blue Ribbon Research Commission and the previously mentioned figure of $261.8 million, a total of $18.2 million, could be directed to rehabilitation research and health services research programs.

Mr. Chairman, The American Legion supported the establishment of the Blue Ribbon Research Commission study when initially proposed. Now, we fully endorse and support the conclusion of the Commission's review. VA supported research programs have suffered declining purchasing power since the middle 1980's. It is now time to begin to correct this steady erosion.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The grant program assists the states in acquiring or constructing state home facilities for the furnishing of domiciliary, nursing home, or hospital care to veterans. Public Law 101-237 extended authorization for this program through September 30, 1992.

The funding request for FY 1992 represents a continued commitment to VA's policy of providing a greater share of VA-sponsored nursing home care through less expensive State and community programs and is based on the 1990 backlog of applications. The FY 1992 appropriation request of $85 million will provide for 36 projects which will produce 926 nursing home beds and 250 domiciliary beds.

Mr. Chairman, The American Legion views the proposed FY 1992 State Home construction grant budget very favorably. In fact, the funding level for this program has increased from $41.3 million in FY 1990, to $70 million during FY 1991. The proposed FY 1992 budget will permit VA to fund all currently approved state home grant applications. At the FY 1991 funding level of $70 million, there is still a project backlog request of between $12 and $16 million. The FY 1992 proposal will contribute to eliminating the present application backlog.

The American Legion considers this program a wise investment. Services provided by state homes substantially reduce the funding burden that would otherwise be borne by VA. As we move into a period of a rapidly aging veteran population, the states can be of major assistance to the Federal Government in the care of the aging veteran population through state extended care facilities. In order to materially ease the fiscal pressure on VA, adequate funding must continue to be made available to the states so that the program grows commensurate with the demand for service.

GRANTS TO THE REPUBLIC OF THE PHILIPPINES

The budget proposal provides for a grant of $500,000 to the Veterans Memorial Hospital in Manila to replace and upgrade equipment and to rehabilitate the physical plant and facilities. This grant has been made by the United States consistently since the end of World War II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during World War II. The American Legion believes there is a continuing obligation by this nation to assure the availability of care and treatment for these veterans and we endorse this grant.

CONSTRUCTION PROGRAMS

The FY 1992 budget proposal reflects an overall request of $654 million for construction. This amount is subdivided as follows:

Major Construction - $450 million

Minor Construction - $196 million

Parking Garage Revolving Fund - $8.5 million

When compared to current budget estimates for VA construction programs, the major construction account for FY 1992 represents a decrease of $130 million from the FY 1991 level, minor construction represents an increase of $65 million above the FY 1991 level, and the Parking Garage Revolving Fund shows a net decrease of $21 million from the current year estimate.

Mr. Chairman, we offer our appraisal of the FY 1992 construction funding proposal by individual account.

Major Construction

The American Legion is in agreement with the proposed major construction project selection for FY 1992. Through site visits made by our American Legion Field Service Representatives, we can attest to the need for all major projects proposed for FY 1992 funding. We believe that all of the projects identified must receive the unequivocal support of the Congress.

In addition to the major construction projects identified in the Administration's FY 1992 budget proposal, we believe the need for major construction at several facilities has been omitted. Replacement and modernization of VAMC Ann Arbor, MI and VAMC Dallas, TX, in our view, must receive appropriate attention immediately. These facilities were constructed in 1952 and 1940, respectively, with a major bed addition added to VAMC Dallas in 1952. Both facilities require clinical and outpatient additions and renovations to existing patient environments.

In addition to the above identified VA medical centers, we are perplexed over the delay in approving the construction of a much needed 290-bed psychiatric facility at the Gainesville, FL Medical Center. The need for this facility was long ago confirmed by VA through the now defunct Medical District Initiated Planning Process (MEDIPP). As this Committee well knows, the State of Florida has no long-term VA psychiatric beds and must rely on other VA medical centers in adjoining states to accommodate their long-term psychiatric treatment requirements. In addition to these three identified major construction projects which we believe have too long been neglected, The American Legion recommends that the major replacement project at VAMC Palo Alto, CA be approved as a one-time project for FY 1992.

We believe that based on the identified needs of the VA capital plant system, major construction funding will need to be maintained at no less than $600 million per year for the next decade.

Minor Construction

As buildings get older, increased maintenance needs must be met. The American Legion believes VA has fallen behind over the past decade in keeping up maintenance on its aging facilities, as well as renovation and modernization. A 1990 report on the age distribution of VA hospitals reported the following information.

Age of Hospital	General Hospitals No	% of beds	Psychiatric Hospitals No	% of beds	Total Hospitals No	% of beds
Under 10 years	4	5	0	0	4	4
10-19 years	14	12	0	0	14	10
20-29 years	20	18	1	2	21	15
Over 29 years	113	65	20	98	133	71
Total	151	100	21	100	172	100

Funding for minor construction projects has never been sufficient to meet the growing requirements of an aging VA medical care system, especially in the last ten years. In the past, VA has sought and received congressional authority to reprogram minor construction funding to meet other budgetary shortfalls. The proposed minor construction funding level of $196 million for FY 1992 (minus administrative costs of $46 million), leaves a net amount of $150 million to help meet current maintenance needs.

The American Legion fully supports the proposed FY 1992 minor construction proposal. Further, we are of the opinion that no less than $150 million per year, minus administrative add-on costs, will be required over the next decade to continue to address capital plant construction requirements within VA.

Parking Garage Revolving Fund

During FY 1992, $8.5 million is proposed for the Parking Garage Revolving Fund. This amount represents a decrease of $20 million from each of the previous two fiscal years. The amount of funding proposed for FY 1992 is lower than in previous years due to other major projects involving parking garages having received funding for the parking projects from within funding appropriated for the overall construction project. Therefore, less funding is required for this account during FY 1992.

During FY 1992, available funds are proposed to complete a multi-level parking structure to accommodate approximately 800 cars at the Nashville, TN Medical Center. The American Legion supports this project. In the future we intend to work closely with the VA Office of Facilities to identify those VA facilities which require new parking structures to assure their funding requirements are met.

National Cemetery System

The American Legion finds the Administration's budget proposal for the National Cemetery System (NCS) for FY 1992, embarrassing and totally inconsistent with the budget and staffing requirements of this department. The FY 1992 proposal requests $57.3 million in budget authority and 1,200 FTEE for NCS. This is an increase of $3.5 million and a reduction of 37 FTEE from the current estimate level. The FY 1992 request reflects the costs of the January 1992 pay raise, annualization of the 1991 pay raise and locality pay costs, the increasing costs of personnel benefits, within-grade increases, and the one additional workday in 1992. The budget proposes a one year delay (until October, 1992) in the opening of the new San Joaquin Valley National Cemetery.

Essentially, the $3.3 million funding increase proposed for FY 1992 provides NCS with no new budget authority. All additional funding will be absorbed by personnel related increases and inflationary adjustments.

Mr. Chairman, The American Legion strongly believes that funding for current operations, staffing levels, and new national cemetery construction, all need to be substantially enhanced in future years in order to meet expected workload demands, and to maintain existing gravesites.

In order for the National Cemetery System to reestablish its proper place in the order of VA funding priorities, we recommend a funding level for NCS during FY 1992 of no less than $70 million, accompanied by a FTEE level of a minimum 1,380. The current authorized ceiling of 1,276 FTEE needs to be increased by roughly 100 positions, just to maintain existing gravesites and for future burials. Each year, approximately 60,000 new gravesites are included in the total number of graves and require ongoing maintenance. Unfortunately, Mr. Chairman, NCS today has funding available to only support about 1,215 FTEE of its total authorized level.

At the funding level which we recommend for FY 1992, NCS would be able to address some of the current equipment backlog of approximately $8 million. Additionally, the most active national cemeteries at Riverside, CA and Calverton, NY desperately require augmentation to existing staff levels. The new VA national cemetery in Arizona will require an additional $500,000 and 8 FTEE during FY 1992, for which no funds are proposed. Also, as previously commented, the new San Joaquin Valley National Cemetery in northern California, which has been scheduled to open on Veterans Day, 1991, will have to be delayed one full year due to inadequate resources.

Perhaps the ultimate indignity to veterans and their dependents and survivors, will be limiting burials to only certain days of a week, because without adequate resources NCS staff cannot both bury the dead and simultaneously maintain all required maintenance.

We realize the profile we present on the condition of the NCS is not pleasant. In a time of constrained federal resources we know some sacrifices must be made. However, The American Legion believes that due to the many sacrifices already made by veterans, providing proper and dignified perpetual care is not the place for the budget ax to fall.

The NCS requires a modest amount of funding in order to correct past decremental budgets and then, in the future, annual budget appropriations for NCS operations must be maintained with existing requirements.

VETERANS BENEFITS ADMINISTRATION

Of the Department of Veterans Affairs' total budget request for FY 1992 just more than half ($16.9 billion) would be allocated to the payment of those statutory entitlement benefits provided under title 38, USC. Such benefits include compensation for service-connected disability and death, nonservice-connected disability and death pension, education assistance allowances, and burial benefits. The remainder of VA's annual budget supports the operation of medical care and construction programs, the National Cemetery System, and the General Operating Expenses account which includes the Veterans Benefits Administration (VBA).

The proposed funding for the operation of VBA for FY 1992 includes budget authority of $572.5 million and reimbursements from the Compensation and Pension account of $142.7 million. This will provide for total staffing of 13,140 FTEE to carry out the administration of VA's various programs of direct benefits and services and the operation of the 59 VA regional offices located in the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Philippines. It reflects a net increase of 33 FTEE over the 1991 level as a result of the transfer of 356 FTEE associated with the operation of the Hines and Philadelphia Data Processing Centers from the Assistant Secretary for Information Resources Management to VBA and a reduction of 60 FTEE associated with a net decline in workload, a reduction of 125 FTEE attributed to modernization savings, and a reduction of 138 FTEE resulting from lower workload requirements resulting from the implementation of the Omnibus Budget Reconciliation Act of 1990.

Congress specifically provided additional staffing support in key areas in the FY 1991 VA budget, most of which were associated with the implementation of PL 101-237 - the Veterans Benefits Amendments of 1989 and PL 101-508 - the Omnibus Budget Reconciliation Act of 1990. However, few if any resources were targeted to longstanding problem areas where the timely delivery of benefits and services is particularly staff-sensitive. These areas include the continued deterioriation in quality and timeliness in the processing of benefit claims, the provision of benefit information and services, the lack of counselling and assistance services to disabled veterans and service personnel, and increasing delinquencies and foreclosures in the GI home loan program.

After a careful analysis of current and projected workload data supporting the FY 1992 budget for each service within VBA, The American Legion is deeply concerned by the personnel cuts which will be imposed. In our view, these cuts, if implemented will lead to a further deterioration in the quality and timeliness in VBA operations. We are especially concerned that this budget request does not appear to take into consideration the impact of the current economic downturn on the demand for benefits and services nor the near-term effects of the Persian Gulf crisis on VBA's workload.

Staffing support for the Veterans Services program is expected to be reduced by 31 FTEE below the FY 1991 level due to a projected decline in certain workload requirements associated with PL 101-508 and the implementation of modernization initiatives. Although the budget contains a description of the various program actions planned and underway to improve responsiveness and service, we believe the volume of inquiries and the amount of support needed for veterans' outreach and the transition assistance program for military personnel has been substantially underestimated. Contacts in all forms for needed assistance, education and other benefits by and on behalf of military personnel and their families, particularly those serving in the Persian Gulf, will continue to have a substantial impact on this program. Veterans and others affected by the continuing economic recession seeking benefit and employment information and assistance can be expected to add substantially to the workload in the near future legislation enacted in the 101st Congress restricting compensation and pension benefits, home loans, and medical care eligibility will have in our opinion, a substantial long-term impact on the demand for information and services, as will decisions of the Court of Veterans Appeals.

Since the Veterans Services program is on the frontline in its contacts and dealings with veterans, dependents, survivors, and the public, it is essential that on-going efforts to improve timeliness and quality of service through ADP initiatives continue. However, much of the direct service depends on the availability of adequate numbers of trained and dedicated staff. We oppose any staffing cuts.

In the Compensation, Pension, and Education program, staffing will be increased by 30 FTEE over the FY 1991 level to 4,256 FTEE. The additional 30 FTEE have been identified as needed to handle the increased workload associated with the implementation of PL 101-508. This increase will be more than offset by a decrease of

12 FTEE associated with a decline in workload and 58 FTEE resulting from short-term modernization initiatives. The net effect is a cut in staffing for the CP&E program of 40 FTEE.

The American Legion remains deeply troubled by consistent staffing reductions in this program in the face of the continuing decline reported in the quality and timeliness in the processing of benefit claims. VA acknowledges that in the past 10 years, regional office adjudication personnel have been reduced by more than 35 percent. This reduction has been compounded by a severe problem of turnover among adjudicators. In FY 1991, about one-quarter of regional office adjudication personnel were reported to be trainees. At some offices, it is acknowledged the number of trainees is much higher. This situation affects not only the productivity and the quality of their work, but that of others as well, since most training must be done by trained adjudicators. That takes away from their production time. Efforts to overcome these deficiencies and the mounting backlogs have been impacted by the added workload from recent legislative and regulatory changes intended to improve VA due process and appellate procedures.

Decisions of the Court of Veterans Appeals have also begun to affect the timeliness of VA's adjudication decision-making process, because more time is needed to complete required development of claims and appeals. Complex medical issues associated with the health effects of exposure to Agent Orange, prisoner-of-war disabilities, and many other conditions now require greater expertise and time to properly develop and adjudicate. These and other actions require that existing adjudication staff give more time and attention to the development and processing of all claims and appeals.

According to VA, processing times for claims have continued to increase as have the number of errors being found on quality review checks. These disturbing trends have been highlighted in our budget testimony over the past several years and in congressional oversight hearings on the subject. Each year, VA presents data and statistics projecting declining veteran and beneficiary population, declining caseloads, descriptions of program changes, and management and ADP initiatives in support of a further net decrease in critically skilled staff. Despite the stated budgetary goal of improving service and timeliness, veterans and their families are being forced to wait longer for a decision on a benefit claim and the payment of needed financial assistance benefits to which they are entitled.

Regionalization of the Chapter 30 program and the introduction of new ADP procedures and equipment have helped improve the overall delivery of education benefits. Activity and caseloads are expected to remain at high levels. If we are to ensure the continued timely delivery of benefits and services, it will be necessary to maintain at least the current staffing level.

In the Vocational Rehabilitation and Counselling program (VR&C), The American Legion is concerned by the loss of 24 FTEE under the FY 1992 budget. Congress has focused considerable attention on problems in the program caused by the overwhelming caseloads each Vocational Rehabilitation Specialist is expected to manage. As a result, the budget for FY 1991 specifically authorized 69 FTEE to address this problem. Now, despite the indication of a net increase in workload and additional program responsibilities, such as the expansion of the TAP and DTAP transition assistance programs, the VR&C Service will lose almost one-third of the staffing support gained in the current year budget. In addition, the projected cut in staffing does not take into consideration the impact of an increased demand for vocational rehabilitation and employment services by disabled veterans adversely affected by the current economic recession, nor does it begin to consider the workload associated with the provision of counselling and rehabilitation services to members of the Armed Forces. Automation improvements alone cannot compensate for the loss of skilled personnel in this program who are needed to provide essential counselling services and most important, effective case management.

Mr. Chairman, because of past problems of increasing delays in providing disabled veterans with needed services and benefits as well as insufficient and overburdened staff, the Government Accounting Office (GAO) is currently reviewing the vocational rehabilitation program. We believe the need for continued strong staffing support has been amply demonstrated, not only to ensure that the employment needs of disabled veterans are being met quickly, but that the millions of dollars appropriated each year for this program are being properly and effectively spent.

Another area of concern is the cutback in Support Services by 154 FTEE. It is predicated upon certain ADP modernization savings, productivity improvements, and a decline in workload requirements and follows a loss of 247 FTEE under the current year's budget. We believe these severe and persistent reductions have directly and indirectly contributed to the overall problem of a deterioration in the quality and timeliness of VBA operations. We also believe that too little consideration has been given to the increasing activity associated with recent legislative and regulatory changes affecting the various benefit programs.

As we have noted, FY 1992 VBA staffing levels have been largely based upon productivity improvements as well as current and planned short-term ADP initiatives. We continue to believe there remains a critical need for increased staffing support in the regional offices now rather than later, particularly in view of VA's own data showing a continued decline in the overall quality and timeliness in the delivery of services and benefits. It is likewise imperative that VBA's ADP modernization plan continue as rapidly as possible with the ultimate goal of improving efficiency and quality in service and claims processing, and reach the department's goal of achieving savings in staffing and resources. We are pleased with the continued level of budgetary support for the various ADP initiatives and modernization.

HOME LOAN GUARANTY PROGRAM

Mr. Chairman, this important benefit program, in existence since 1944, has in recent years fallen upon some hard times. Last year this Committee showed leadership in taking steps toward making the program whole again. We hope these steps will have the desired effect. In this context, The American Legion offers comments on some of the legislative proposals made by the Administration with respect to the Home Loan Guaranty Program.

VA guaranteed loans made to purchasers of manufactured homes have played an important part in helping families of moderate means to attain a portion of the American dream. At the same time, loans on manufactured homes have historically proven to be riskier than those made for conventional homes. While we understand that the downpayment requirement is intended to force the veteran borrower to acquire an equity stake in his home, thus lessening the risk, we are not sure that 10% is the right number. We believe that the proposed 10% downpayment requirement in conjunction with a 2% user fee is excessive.

We are opposed to making the current funding fee structure permanent. The .625% increase passed as a result of last year's budget agreement was levied in an attempt to reach accord on federal spending. Making the .625% increase permanent is not acceptable. The increase should be temporary.

If some efficiencies are to be gained by merging the Loan Guaranty Revolving Fund and Direct Loan Revolving Fund, The American Legion has no objection.

The Administration also proposes to change the regulations governing the acquisition of property on defaulted loans to provide for the inclusion of the losses incurred on resale of property in the calculations. As we understand the current process, the holder of the defaulted loan has the option to convey the property to VA only if the "net value" of the property exceeds the total indebtedness minus the amount of the guarantee, or if a larger bid was made for the property as a minimum amount permitted under State law. Net value is defined as the fair market value minus the cost of acquiring and disposing of the property including taxes, maintenance and resale expenses. Adding the cost of losses incurred by this calculation only lowers the net value of the property, making the veteran liable for payment of additional monies should VA not be able to sell the property at a price above what the veteran owes on the loan. This is not acceptable. Often when a veteran loses his home, he or she loses everything; it is extremely unlikely that VA will ever be able to collect.

Mr. Chairman, the Administration proposes to cut staffing in the Home Loan Guaranty Program by 114 FTEE by automating certain functions of the loan approval process. Rather than eliminating these people, we suggest that all or at least some of those 114 positions be transferred to the loan servicing function. A study conducted in Houston two years ago showed that a substantial number of defaults could be corrected and foreclosures prevented by more effective and aggressive loan servicing.

DEPARTMENT OF LABOR PROGRAM BUDGET

We are aware that this budget was constructed prior to American forces entering the war in the Persian Gulf. It is imperative that this Committee acknowledge that funding is necessary to ensure that programs are continued in such a manner as to serve the people returning from Operation Desert Storm. In the case of Labor Department programs, we recommend additional appropriations from Federal Unemployment Trust Account monies, or as an alternative, from a Department of Defense supplemental appropriation targeted specifically at Operation Desert Storm costs.

Mr. Chairman, The American Legion has some serious concerns with the budget request for the Veterans' Employment and Training Service. The Administration portion of the budget funds 288 FTEE and is, in our view, marginally adequate to accomplish the required audits of state operations and the likely increase in Veteran Reemployment Rights arising as a result of Operation Desert Storm.

However, the grants portion, funded out of the Federal Unemployment Trust Account (FUTA), is not enough to maintain the mandated level of 1600 Local Veterans Employment Representatives (LVERs). The budget request only allows for 1492 at a dollar amount of $74.223 million. We suggest that a total of $80.196 million to fund all 1600 mandated LVER positions is a more realistic figure.

The request for the Disabled Veterans Outreach Placement (DVOP) program is more troubling. You will recall, Mr. Chairman, that you signed a joint letter to the President informing him of Congressional intent with regard to the delimiting date in the DVOP allocation formula with regard to Vietnam era veterans. The Administration totally ignored the suggestion contained in the letter, and instead, has declared that Vietnam era veterans do not need the DVOP program any more.

It makes no sense to dismantle a system which has worked successfully to place veterans in jobs in the face of a continuing requirement to provide that service. Accordingly, we urge an authorization of $81.3 million to ensure that Operation Desert Storm veterans and those veterans released as a result of downsizing of the Armed Forces have access to this important program.

Mr. Chairman, the FY 1992 budget request for Department of Labor veterans' programs contains no money at all for the National Veterans Training Institute. NVTI has been uniquely successful in training people from employment service offices across this nation in dealing successfully with veterans and their employment problems. Much yet remains to be accomplished. New LVERs and DVOPs entering the system need the core courses. The case management module has only recently been piloted and is nearly ready to become part of the curriculum. Local office managers need to be trained. We recommend $2.9 million to fund the third year of the three year contract which was initiated in 1990.

There is another portion of the federal budget for which the Assistant Secretary of Labor for Veterans' Employment and Training has had administrative responsibility. The Stuart McKinney Act monies have in the past included some funds to be used to assist homeless veterans. In 1991, $2.018 million was included for the Homeless Veterans Reintegration Project (HVRP) administered by the ASVET. This project completed intake on nearly 5800 veterans or 121% of the goal. Over 2200 were placed in jobs.

It is our understanding that all McKinney Act funds will be administered by the Department of Housing and Urban Development for 1992. We urge this Committee to ensure that homeless veterans, who make up at least one third of the homeless population, are not lost in the shuffle of a change in responsibility for administration of important homeless programs.

The American Legion continues to be concerned about the precarious nature of employment tools used by DVOPs and LVERs: the Veterans' Job Training Act (VJTA) and the Targeted Jobs Tax Credit (TJTC) and Title IV-C of JTPA. Although PL 100-323 extended VJTA for two years, the FY 1990 and FY 1991 budgets for VA failed to fund this program, which was tailor-made for Vietnam era and Korean War veterans. Likewise, the FY 1992 budget ignores the program. Since its inception, over 22,000 veterans have successfully completed training and are now employed in meaningful jobs. They are now taxpayers; assets rather than liabilities to their communities. The program is even more important now that Operation Desert Storm is under way. We urge its reauthorization and adequate funding.

Although TJTC does not fall under the jurisdiction of this Committee, it is another program used by DVOPs and LVERs to get veterans off welfare rolls and onto payrolls. The second session of the 101st Congress gave TJTC an extension to the end of FY 1991. Vietnam era veterans are only one of the groups specifically targeted by TJTC. Over 35,000 veterans have re-entered the work force thanks to TJTC. We would ask this Committee to help us persuade the Ways and Means Committee to make TJTC a permanent employment tool. TJTC provides a small tax incentive for employers to hire those citizens identified as economically disadvantaged.

Much was said during the presidential election campaign about the Job Training Partnership Act (JTPA) and its impact on helping Americans get good jobs. Each year, the amount of funds allocated to Title IV-C for veterans has remained disproportionately low. We would ask this Committee to help us seek favorable action by the Committee on Education and Labor to increase Title IV-C dollars to a minimum of $60 million.

LEGISLATIVE INITIATIVES

In order to achieve the proposed funding level for FY 1992, the budget request sets forth approximately $609 million in net savings associated with certain legislative proposals which will be included in the President's legislative program for the First Session of the 102nd Congress.

# The Department of Veterans Affairs recommends a cost-of-living adjustment (COLA) of 5.2 percent effective December 1, 1991. This legislation will also propose indexing future disability compensation and dependency and indemnity compensation (DIC) COLAs to the annual change in the Consumer Price Index (CPI).

Obviously, compensation benefits to service disabled veterans and their survivors must keep pace with increases in the cost of living. Historically, Congress has authorized fair and timely adjustments in these benefits. The American Legion is opposed to that provision which would index compensation COLAs to changes in the CPI and we have testified in opposition to similar proposals a number of times. Of equal importance and consideration in this matter is that legislative hearings on proposed cost-of-living adjustments before the Veterans Affairs Committees provide a forum at which other compensation related issues, such as special monthly compensation criteria, benefit reform, and problems affecting veterans, may be discussed. Should indexing be enacted, there may not be an opportunity to bring such matters to the attention of the committees responsible for ensuring the welfare and well-being of our nation's veterans.

# Proposed legislation would eliminate the sunset provision on limiting the estates of certain incompetent veterans to $25,000. This limitation was imposed under the Omnibus Budget Reconciliation Act of 1990 - PL 101-508 and is to remain in effect until September 30, 1992. The current restriction is grossly unfair. It discriminates against veterans suffering from severe mental disorders and places arbitrary limits on benefits to which they are justly entitled. It is overly intrusive, and needs to be eliminated entirely. In our opinion, the administration of this requirement adds a further and unnecessary burden on already limited regional office staffing resources.

# Proposed legislation would eliminate the sunset provision on VA's authority under PL 101-508 to obtain certain income information from the Internal Revenue Service and the Social Security Administration for the purpose of verifying reported income information of individuals receiving needs-based disability and death benefits and service disabled veterans receiving increased compensation based on individual unemployability.

Over the years, The American Legion supported VA's efforts to improve the timeliness and accuracy of its benefit payments and to ensure the fiscal integrity of the benefit programs authorized by Congress. Limited studies of the problem of overpayments has indicated VA's need for access to income information in the records of the Internal Revenue Service and Social Security Administration to verify benefit eligibility. We support making the current authority permanent, in view of the size of outstanding overpayments and future cost-avoidance. However, the magnitude of the workload associated with this initiative will require additional VA staffing resources in order to achieve the intended goal.

# Legislation would be proposed to eliminate the sunset provision for the reduction of pension benefits to $90 a month for any veteran without spouse or child who is receiving Medicaid coverage and who is in a Medicaid-approved nursing home.

Under PL 101-508, monthly pension benefits to Medicaid eligible single veterans in Medicaid-approved nursing homes were capped at $90 through September 30, 1992. We do not support the current limitation, and we sure do not want it extended.

# In addition, proposed legislation would increase the wartime service requirement for pension eligibility purposes from 90 days to 180 days, for all claims filed after October 1, 1991.

The current eligibility criteria of 90 days or more of wartime service was established for entitlement to Improved Pension under PL 95-588. The American Legion is opposed to any further restriction, because it arbitrarily discriminates against wartime veterans who might otherwise be eligible for the current pension program.

# Proposed legislation would also statutorily limit vocational rehabilitation training and services to service disabled veterans rated 30 percent and above.

Under the Omnibus Budget Reconciliation Act of 1990, basic eligibility for vocational rehabilitation as provided by Chapter 31 of title 38, USC was increased from 10 percent to a minimum of 20 percent for the purpose of achieving certain budget savings. In our view, the current restrictive criteria as well as the further proposed restriction fail to recognize that the fundamental and historical purpose of the vocational rehabilitation program is to assist veterans with compensable service-connected disabilities overcome an employment handicap caused by their disability.

In 1962, the eligibility criteria which required only a compensable level of disability was revised to limit vocational rehabilitation to veterans rated 30 percent and above. However, it also provided that if rated less than 30 percent vocational rehabilitation could still be approved where such disabilities were clearly shown to have caused a pronounced employment handicap. In 1980, this restriction was liberalized to require only compensable service-connected disability causing an employment handicap which is the same criteria as was required under the Veterans Readjustment Act of 1944, the original GI Bill which was sponsored by The American Legion.

We are opposed to both the current and proposed restrictive eligibility criteria as it fails to provide for those service disabled veterans who, while not meeting the statutory 20 or 30 percent requirement, have a severe employment handicap and would benefit from vocational rehabilitation.

# Another legislative proposal would limit eligibility to Survivors and Dependents Educational Assistance to either natural or adopted children of the veteran. This provision would eliminate the eligibility of a veteran's stepchildren for education

assistance under Chapter 35 of title 38, USC of the purpose of budget savings of $1.1 million.

The American Legion is opposed to any measure which seeks to deny children, who were otherwise dependents of the veteran, the opportunity for an education which may have been lost or restricted by reason of the veteran's death.

Proposed legislation would allow VA to be competitive with other Federal and non-Federal employers in the recruitment and retention of physicians and dentists. This initiative would permit flexibility in determining the amounts of special pay based upon differences in individual qualifications or the nature of the assignment. An increase of $41.5 million is proposed to support this action in FY 1992. The American Legion has consistently supported this proposed legislation. The flexibilities built into the changes will allow VA to maintain an adequate professional workforce.

# An initiative to expand VA operated Child Care Centers is proposed. Such child care centers will be established based on the demand for care, practicality and the best interest of VA. An increase of $1.2 million is requested to support renovation/construction costs necessary to meet State and local regulations. The American Legion has no objection to this proposed legislation.

# A decrease of $6.4 million in spending is proposed to permit VA to purchase sheets, pillowcases, blankets, towels and other textiles for VA patients by competitive procurement instead of from mandatory sources regardless of any other existing statutory or regulatory provisions. The American Legion does not offer any objection to this proposal so long as high quality standards are maintained in VA textile procurement practices.

# Another proposal would limit beneficiary travel benefits to eligible veterans residing in "rural areas" 50 or more miles distant from a VA medical treatment facility. Veterans who live within the 50 mile radius of a VA medical facility will not be entitled to any beneficiary travel benefits. Besides satisfying the mileage requirement, the proposal states veterans must be receiving care for a service-connected condition, be rated at least 50 percent service-connected for any condition, or have income less than the Category A income level. This initiative proposes a decrease of $62.9 million in funding authority.

The American Legion is mandated to oppose any dilution or elimination of benefits currently payable to veterans. We have consistently supported cost containment in the beneficiary travel account through careful management of the program. The current proposal does not contain sufficient language to ensure that poor infirmed veterans or nonservice disabled veterans, who would be excluded from receiving beneficiary travel reimbursement by this legislation, could adequately obtain, at a reasonable cost, public transportation from their residence to a VA medical facility and back. The American Legion believes that beneficiary travel reimbursement must be considered on a case-by-case basis for those veterans who would otherwise be ineligible from receiving this important benefit. We feel this proposal could restrict some veterans from receiving necessary VA health care.

# Two additional proposals related to VA's Medical Care Cost Recovery Fund and Medical Fee program would permanently authorize the expansion of third party insurance recovery, currently authorized by the Omnibus Budget Reconciliation Act of 1990 (OBRA) - Public Law 101-508, thru the end of FY 1993 and make permanent the copayment provision of OBRA which is set to expire at the end of FY 1991. Additionally, the proposal would authorize the collection of means tested copayments from veterans with service-connected disabilities rated at 40% and below for treatment of nonservice-connected conditions.

The provisions under OBRA that would be extended amend title 38 to: 1) combine former eligibility Categories B and C into one group and to impose new copayments on those veterans of $10 per day for inpatient care and $5 per day for nursing home; and 2) require VA to charge a $2 copayment for medication furnished to veterans, except those rated at least 50 percent and those receiving medication for a service-connected disability.

The American Legion opposed enactment of the means test and third party programs as legislation that was unnecessary and inappropriate. These programs have effected essential changes in the nature of the VA health care program by making it a cost-sharing program rather than a benefit program as intended by the American people. In our view, it is doubtful that any more substantial dollars will be realized than the cost of the paperwork involved for the proposed copayment programs. Additionally, the proposed copayment programs may cause some veterans to not seek VA health care due to their personal economic conditions.

The American Legion is mandated to oppose the requirements of the means test and third party reimbursement programs and we do not support the proposed initiatives.

OPERATION DESERT STORM

We recognize that this budget was put together before the large buildup of troops in Operation Desert Shield, and before the beginning of Operation Desert Storm. And we appreciate Secretary Derwinski's commitment to seek a portion of any Defense supplemental appropriation to help pay for problems brought on by the activities in the Persian Gulf region.

Those of you here understand as we do that the cost of wars can go on long after the hostilities end. This war will bring on special problems we cannot now anticipate.

So far, since January 17, Congress has responded with dozens of proposals to help the veterans of Operation Desert Storm. Some of the most innovative approaches have come from members of this Committee.

Mr. Chairman, The American Legion commends you for your leadership on this issue, and we look forward to working with you to address the special needs of our men and women in the desert, so far their home homes.

In the coming months we will be looking at your proposals, and we will be developing our own initiatives to speed the readjustment of these veterans to society, and to find a way to pay the wages of war.

CONCLUSIONS

Mr. Chairman, in this statement we have set forth the sincere opinions and positions of The American Legion on a variety of subjects that are included in the Administration's budget proposal for FY 1992 which we consider to be of special importance to the nation's veterans. We have addressed those programs we believe to be of highest priority in a department whose activities are all of high priority. They are intended to meet the needs, first of those who were disabled in service, then the reasonable needs of all those who have served honorably when called to do so by this nation. We also believe that the benefits bestowed by a grateful nation to our servicemen and women must be provided in a timely, comprehensive and quality manner.

The American Legion is grateful for the efforts of this Committee which helped to secure a Department of Veterans Affairs budget for FY 1991 that represented an increase over the previous year's funding level. Again, Mr. Chairman, a significant challenge lies before us in obtaining a responsible FY 1992 Department of Veterans Affairs budget.

We believe it is necessary to comment again this year on the problems being experienced in the provision of quality and timely medical care and benefit programs provided America's veterans. We earnestly support the proposed FY 1992 medical care budget proposal, but we do not believe the proposal will adequately restore the erosion of real dollar increases which VA has experienced over the past decade. Additionally, the FY 1992 funding proposals for the National Cemetery System and Medical and Prosthetic Research activities are depressed and will require considerable correction. We also believe a strong commitment must be made in adequately funding the medical construction requirements of VA in the years ahead.

VA once again forecasts that service to veterans and other claimants will improve in 1992, despite obvious cutbacks in regional office personnel in almost every activity. In support of requested staffing levels, VA projects an incremental decline in the benefit caseload, enhanced productivity, and personnel savings associated with short-term modernization initiatives. The problem with this scenario is that service and productivity have in recent years seriously deteriorated and during the same period, ADP improvements and program changes have not made up for the persistent loss of experienced personnel. Consistent with OMB's continuing policy, VA has been repeatedly forced to trade off personnel resources in order to obtain ADP equipment to continue its overall modernization program. In our opinion, there must be a tangible and substantial improvement in the level of service provided by VBA, as evidenced by more timely processing of benefit claims with fewer errors, before considering any reduction below the FY 1991 staffing level.

Given the fact that this nation is currently in an economic recession coupled with the continuing conflict in the Persian Gulf, we sincerely believe that VA could have and should have made a more serious attempt to assess the potential impact of these factors in the development of their budget request for FY 1992. The Department has both the responsibility and expertise available to make reasonable and realistic estimates as to the need for benefits and services in the immediate future.

The American Legion appreciates this opportunity to present its views on the proposed FY 1992 budget. We trust that this Committee will examine and consider the problem areas we have identified, and that these issues will be substantively addressed in order to assure that veterans and their families receive the financial assistance and support intended by Congress.

We have commented specifically on those areas which we feel present the most glaring problems, and we have responsibly addressed each of the legislative initiatives with respect to the concerns of The American Legion. No doubt, we will be sharing additional thoughts with the Committee as the budget process moves forward during the next several months.

Mr. Chairman, that concludes our statement.

Vietnam Veterans of America, Inc
1224 M Street, NW
Washington, DC 20005-5183

(202) 628-2700
(202) 628-5880 fax

STATEMENT OF

VIETNAM VETERANS OF AMERICA

by

THOMAS A. SHERWOOD

EXECUTIVE DIRECTOR
DIRECTOR FOR HEALTH POLICY & PLANNING

Before the
HOUSE COMMITTEE ON VETERANS AFFAIRS
on

FISCAL YEAR 1992 BUDGET
FOR THE DEPARTMENT OF VETERANS AFFAIRS

February 20, 1991

★ A not-for-profit national veterans' service organization ★

Mr. Chairman and members of the Committee, the Vietnam Veterans of America appreciates the opportunity to present its views on the fiscal year 1992 Veterans Programs Budget. According to the Budget of the United State Government, Fiscal Year 1992, Budget Authority (BA) and Appropriations for programs in compensation will decline by 0.971 percent and the average number of compensation cases and payments will decline by 0.987 percent using 1990 actual vs 1992 estimates.

Budget Authority and Appropriations for programs in pension will increase by 0.996 percent, total veterans on pension will increase by 0.994 percent while survivors will decrease by only 0.980 percent. In short, relative to Compensation and Pension programs, it would appear little activity is perceived for these functions at least on the demand side.

Unfortunately, the potential for a deepening recession, increasing unemployment and creeping inflation in spite of rosy predictions can adversely alter circumstances such that even with building a more equitable system relative to the taxpayer who foots the bill, the veteran will be economically severely impaired.

On the supply side, the President's budget proposes savings of $160 million in BA in 1993 and $672 million over four years in Compensation. The budget also proposes a $280 million savings in 1993 and $1.3 billion over four years in Pension programs.

Additionally, the President's budget proposes a savings of approximately $300 million from several changes in the VA housing program including a required down payment of 10 percent and fees of 2.5 percent for multiple use loans, and an extension of current loan origination fees as well as legislation to allow VA to include the losses that occur on the resale of properties in the net value calculation.

There are also proposed savings of $11 million in Fiscal Year 1992 and $120 million over 5 years from limiting vocational rehabilitation to veterans with service-connected disabilities rated at 30 percent or higher. We need to be clear that these savings are a part of the veteran's contribution to a failed Gramm-Rudman-Hollins Deficit Reduction program which has not met its 1991 targets of a balanced federal budget and has been projected into the year 1996. In spite of all the rhetoric, the borrowing on the future will continue.

Veterans will resent paying on this deficit well into the future since they did not cause it. Additionally, veterans are subject to what appears to be a quadruple whammy! As citizens they too will have to pay for the S and L debacle, the so-called bailout. They will also bear their share of the burden for the interest on the national debt and inflation. They will also bare the burden of the cuts the VA will have to absorb for the sake of the 1991 budget "deal." And finally for many veterans, there will be no safety net. If the veteran could only get a quality product at least from the VA in order that he/she might say at least for all the pain, something was worth it.

Continuing and citing the President's budget as noted from the Committee on the Budget of the U.S. House of Representatives, the proposed budget for VA medical care is $13.3 billion for fiscal year 1992, an increase of $950 million or about 8 percent above the 1991 funding level. This includes a $41 million increase for special pay for health professionals but would limit beneficiary travel to eligible persons who reside in rural areas 50 or more miles from a VA medical facility.

On this issue of limiting beneficiary travel, the VA needs to be aware that many veterans have an extremely difficult time getting to VA facilities that are 50 miles away from their homes or less. Ironically, even in urban areas, transportation is often inaccessible and/or very expensive. Other savings the VA is to achieve is by extending co-payment packages for treatment of non-service-connected disabilities for service-connected veterans rated at 40 percent or lower.

Our concern here is that the brunt of the agony associated with sorting out which part of the veteran's body is service-connected and which is not will fall to the veteran once he or she engages the system. We need to be aware that we are asking those who served this country in toto to be serviced in parts. We would assert a principle of holistic medicine which asks the veteran be treated as a whole person.

We understand the principle of limiting treatment to service-disabled veterans as budget priorities may dictate. It is a principle we support. But the VA will have to do a better job of treating the veteran as a whole person such that when a veteran who is service-connected presents to a VA medical facility with non-service connected disorders, he/she is not made to feel they are criminals or inadequate.

If it is given that it is not always clinically easy to separate the service-connected disability from the non-service connected complaint, then the VA needs to have a sense of compassion for the veteran in dealing with this issue, and to have in place those systems which allows the veteran to seek alternative treatment options with dignity.

In terms of the "cuts" the VA will have to absorb, there appears to be a strategy of reducing benefits to be equated to making the system more efficient, reducing the veteran's role as a participant in decision-making while collecting more fees and co-payments. On the other hand, it certainly is appropriate for the VA to be compensated by Medicare for caring for veterans 65 and over;

it certainly is appropriate for the VA to be compensated for services they provide to non-service connected veterans who have third party insurers.

If the VA can realize health care savings by participating in joint ventures through organizational efforts with the Department of Defense, the Bureau of Native American Affairs and/or the private sector without these ventures adversely affecting veterans primarily by reduction of quality services, VVA can support them. Our hope is that the Department does not "go fad" and does so for the wrong reasons. We can still remember "fads" such as POMR (the problem oriented medical record); we still have DRG's (diagnostic related groups), U/R (Utilization and Review), Q/A Quality Assurance), and RAM (Resource Allocation Methodology) in distorted versions.

The latest interest of the VA is TQM (total quality management). The irony of this methodology is its expectation that those who create and deliver the product will be empowered, allowed to self manage and self supervise, allowed to determine the value of their products, and have considerable input relative to the product to their "superiors." I have no sense that VA superiors or even the Congress intends to relinquish their influence and control on the system. Therefore, TQM is doomed before a foothold is gained in the VA.

There is much documentation these "projects" have not worked out for the veteran receiving services probably because they have become more associated with politics than client services. And even for those projects mandated by the Congress such as the Pilot Program On Hospital Management Efficiency, a part of the Veterans' Health-Care Amendments of 1986, in which the goal was to "deliver services in a more timely, responsive, efficient and effective manner," there are indications VA Central Office interests were minimal relative to any kind of sincere support, hence, that project for all practical purposes appears not to have had the opportunity it deserved.

We note that in real as well as relative dollars, the VA budget is getting smaller while the overall budget of the nation which approaches $1.5 trillion, is getting larger. This implies a shift in priorities away from veterans at an even greater rate than usual.

During these times of war in the Persian Gulf, we find it necessary to stress to both congressional and VA executive interests the need for the VA to "bill" the department of defense for its contributions and efforts as a backup to the Department of Defense - a relationship created out Public Law 97-174, the VA/DOD Health Resources Sharing and Emergency Operations Act. Our understanding is that the VA will come to Congress for a supplemental, if needed, at a later date.

The problem with this approach is if budget requests are on a pay-as-you-go basis which basically requires to one find the dollars from other programs, the VA, once the war is over, will not be able to obtain additional funding without many more veterans suffering for the want of resources. This will be particularly sad if we, God forbid, get into a ground war in the Persian Gulf, and sustain many casualties requiring long term rehabilitation.

We really do not want to revisit the Life magazine coverage of '70's suggesting the VA was not only unable to care for veterans in dire need of rehabilitation, but insensitive its mission and call to duty. We need to be clear that whereas there is a need to fund the VA now for its efforts relative to Operation Desert Shield and Desert Storm beyond the budget numbers called for fiscal year 1992, there will be a far greater need to position for funding a rehabilitative capability for the VA in the near future.

Funding and the VA budget was one of the important reasons why we in previous testimony supported the executive role of the Secretary basically indicating that he deserves the opportunity to "run his own show" without the micromanagement of either the Congress, or the Office of Management and Budget. In terms of his initiatives on Agent Orange including compensation for Non-Hodgkin's Lymphoma and soft tissue sarcomas, he has shown a special compassion for veterans. In terms of his temporary suspension of law in which he discontinued for a brief period, beneficiary travel, which created hardships for some veterans, we had wondered if he had input from the clinical staff including the chief medical director before he made that decision. In terms of his decision to grant readjustment benefits to other than Vietnam era veterans, the jury is still out although that issue will soon be made moot by legislation presently pending to expand such services. Nevertheless, the Secretary has fought for and obtained dollars for the VA.

However, the veteran, especially the poor, the sick, the elderly, the uninsured, and those veterans without any true constituency to forcefully speak for them - those veterans for whom we would like to think the VA really exists, are definitely not doing well by the VA. The system may be going great guns - salaries increasing, more visibility for the VA in the public eye (good and bad), the appearance of many more executive appointments, the "cabinet status" attention for which veterans are understandably proud, the "modernizing" of the bureaucracy, the benefitting by service providers through research, education and clinical affairs from their association with the VA, and the existence of so many jobs by virtue of veterans affairs, but the veteran is not doing as well.

Many veterans in need still cannot get to a VA hospital, still cannot obtain beneficiary travel, cannot get required and entitled services and treatment without considerable "hassle" if at all.

Veterans are still being told "there is not enough money in the budget" as a reason for denying services to them, and yet, the VA treats only 10 percent of the veteran population in this country.

Before we conclude our statement, I will leave you with a quote from a veteran visiting a tertiary VA hospital on the East Coast, a veteran who is old, alone, without any health insurance and other than his telephone call to me, is in his mind, without anyone who can help him.

"When I go to that place, with all its machines, all its white coats, all its people, all its money, I have a real feeling that place is not for me or my fellow brother and sister veterans. It's for the people that run it, not for me."

Finally, as noted earlier, rehabilitative long term health care programs are very expensive. We are hopeful when VA budgets are constructed, this important fact is taken in consideration. For example, we note that for fiscal year 1992, the amount of dollars obligated for the AIDS program is $325,366,000 which is an increase of $75,056 over fiscal year 1991; which almost doubles the actual for fiscal year 1990. It is clear the VA was able to recognize and convey that this is a very expensive program if they are going to be about caring for these veterans. The VA needs to assure that those dollars actually go into the care of these veterans at the medical center level and are not lost or diffused in the overall medical center budget.

Of particular note are the long needed additional dollars obligated in 1992 for Post Traumatic Stress Disorder treatment including specialized inpatient PTSD units (SIPUs), PTSD Clinical Teams (PCTs), PTSD Substance Disorders (PSU) demonstration projects, the National Center for PTSD (NC/PTSD) and other projects. The increase in obligated dollars for Fiscal Year 1992 over Fiscal Year 1991 by $2,342,000 for the Readjustment Counseling Service Vet Centers comes just in time given the pending expansion of its mission in treating other than Vietnam era veterans. This program, like other programs with long and short term rehabilitation possibilities will have to be constantly monitored for adequacy of funding over time. This completes our statement.

NCOA®

Non Commissioned Officers Association of the United States of America
225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

STATEMENT OF
RICHARD W. JOHNSON
DIRECTOR OF LEGISLATIVE AFFAIRS

before the

COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

FY 1992 DVA BUDGET REQUEST

FEBRUARY 21, 1991

Chartered by the United States Congress

Mr. Chairman, the Non Commissioned Officers Association sincerely appreciates this opportunity to comment on the Department of Veterans Affairs budget request for FY 1992. Overall, the Association is disappointed in the administrations presentation.

Not withstanding some proposed increases in medical care spending, this budget continues a pattern of maintenance spending for veterans programs begun several years ago. No real growth is provided in the proposal. Indeed, increased medical care co-payments, increased loan fees, reductions in construction and cemetery funding all constitute further degradation in benefits.

It is the continued degradation of benefits which bothers NCOA the most. Instead of focusing on the need to provide a package of veterans benefits commensurate with wartime service in the Gulf, the administration seems dedicated to the idea of providing the minimum spending necessary to preclude the total collapse of veterans support programs.

Chairman Montgomery's recently introduced bill, H.R. 908, the Persian Gulf War Veterans Benefits Act of 1991, takes an important stride toward creating the kind of war time benefits package veterans have a right to expect. Yet, if our understanding is correct, Mr. Montgomery proposes to finance his proposal with allied contributions. Frankly, it makes little difference where the money comes from-- but the availability of the benefits should not be dependent on foreign contributions. These are veterans of the U.S. Armed Forces and the responsibility we have to them is ours alone.

Accordingly, in its report to the Budget Committee, NCOA urges the Committee on Veterans Affairs to seek funding for appropriate increased services and benefits to veterans.

Medical Care

Once again the Non Commissioned Officers Association has endorsed, in general, the Independent Budget of Veterans organizations. At this time we specifically endorse those provisions related to veterans medical care and research funding. We believe the independent budget presents a more realistic picture of the funding needed to provide equipment replacement, proper staffing, patient services and research. We urge the committee to fund the Independent Budget for medical care.

Education, Training and Employment

MGIB

The Association strongly encourages the committee to review several issues concerning the Montgomery G.I. Bill as a matter of equity to those serving in Operation Desert Storm. Among the most important is waiver/refund of the $1,200 participation fee.

As the committee knows 70,000 Soldiers, Sailors, Airmen and Marines have been conscripted into extended service to meet the manpower requirements of Desert Storm. Shamefully, many of these conscripts who entered service between 1977 and the implementation of the MGIB in 1985 are not eligible for any G.I. Bill.

Funding should be provided to make free education benefits available to all Desert Storm veterans who serve for more than 90 days during war time and more than 180 days of active duty including reservists in the same way benefits have been provided previous war time veterans.

The value of Montgomery G.I.Bill benefits should also be increased. In this regard NCOA supports the provisions of the Chairman's bill, H.R. 908, which would raise regular component benefits to $500 and reserve program benefits to $250. NCOA also endorses indexing in these programs and restoration of benefits lost due to deployment during a period of enrollment. The Association also asks that the committee make available free GED training to all active duty and veteran servicemembers who do not have a high school diploma.

Finally, if participation fee refunds are not provided to all MGIB participants, NCOA recommends that consideration be given to refunding fees to those who become disabled.

Vocational Rehabilitation

NCOA encourages the committee to resist accepting the savings proposed by limiting eligibility for vocational rehabilitation training. With an ongoing war in the Persian Gulf and the virtual certainty that it will produce casualties, this type of program change is the wrong signal to send to our veterans.

Employment

Although not a part of the DVA Budget, the Department of Labor has recommended significant reduction in Veterans Employment and Training Service funding. Most severely affected will be Disabled Veteran Outreach Program and Local Veterans Employment Representative funding and end strength. Overall the department proposes reductions of more than 500 positions.

Current Defense planning calls for the immediate release of 70,000 servicemembers upon the conclusion of Desert Storm. Another 138,000 to 200,000 will be released in the next year. All will be seeking employment in a recession economy and will need all the assistance government can provide. Accordingly we urge the committee to resist any reductions in VETS program funding.

Housing and Memorial Affairs

The Department of Veterans Affairs has proposed placing further restrictions on guaranteed home loans in FY 1992. Again, NCOA believes the agency to be misguided in its thinking. Requiring higher fees and down payments from those using reinstated benefits penalizes those who have already demonstrated their desire and ability to fulfill their obligation.

Furthermore, loans on reinstated entitlements are probably more sound investments than initial loans. It appears the Department is simply going after the deepest pocket in search of new revenue sources. The Association opposes this proposed change.

Again we reference for the committee the benefits which have traditionally accompanied war time service in the armed forces. Home loan guarantee's, without fees, have been among the most beneficial to both veterans and the communities in which they live. We urge the committee to repeal the loan administration fee for war time service and to extend the benefits of the loan guaranty program to members of Reserve and Guard components.

Memorial Affairs is probably one of the most neglected programs within the Department. This year, in spite of anticipated system expansion, the administration proposes only a meager increase in funding and a decrease in staffing. NCOA can only encourage the committee to oppose further neglect of the National Cemetery System. Concurrently, the Association asks the committee to seek funding to award burial flags and allow the burial of retired or retirement eligible reservists in National Cemeteries.

Compensation, Pension and Insurance

DIC

NCOA strongly supports the Department of Veterans Affairs proposal to reform the Dependency and Indemnity Compensation (DIC) program. Its proposal to convert to a flat rate system fulfills a long-time goal of the Association. We urge the committee to support this initiative.

I do not mean to suggest NCOA is satisfied with the rate of DIC selected. Certainly the Association wishes the rate was higher. Yet we know this number is budget driven and while the change will obviously have an adverse effect on some future senior NCO survivors we believe it an equitable trade. We encourage others to join us in setting aside their parochial concerns in favor of the greater good.

The Association also urges the committee to review last year's decision prohibiting the reinstatement of DIC benefits upon the termination of a surviving spouses remarriage. NCOA does not object to the long term repeal of this benefit. However, many survivors who are remarried have already made irrevocable financial decisions on the basis that reinstated DIC benefits would be available if their second spouse predeceases them. Therefore we believe it would only be fair to allow reinstated DIC benefits to survivors who were already remarried on the date of enactment.

Compensation

The Association is grateful to the administration for the cost-of-living increase in disability compensation and survivor benefits on December 1, 1991. However, the Association continues to oppose the indexing of compensation increases. It is the belief of the Association that the annual review of veterans programs precipitated by the need to pass a compensation bill is more important than the advantages indexing would bring.

Insurance

During the entire Vietnam war the extra-hazard premium paid by the U.S. government for combat deaths was less than that expended on ordinance during any month of the war and less than the cost of a B-1 bomber today. Yet, the anticipated and widely misunderstood cost of extra hazard premium has many people convinced it would be too expensive to increase Servicemens and Veterans Group Life Insurance SGLI/VGLI coverage at this time. The Association strongly disagrees and urges the committee to go forward with an increase in benefits to $100,000.

NCOA also recommends that VGLI coverage be extended to retired military personnel subject to recall. This benefit is already available to reservists but has been denied to retirees, many of whom are now serving in the Persian Gulf.

Conclusion

Altogether, NCOA is deeply disappointed in the budget

Institute of Gerontology

The University of Michigan
300 North Ingalls
Ann Arbor, Michigan 48109-2007

Telephone: (313) 764-3493
Fax: (313) 936-2116

Richard C. Adelman, Ph.D.
Director and Professor of Biological Chemistry

February 28, 1991

The Honorable G. V. Montgomery
U.S. House of Representatives
Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Montgomery:

Thank you very much for the invitation to submit testimony on the fiscal year 1992 budget for the U.S. Department of Veterans Affairs. My relevant views pertain more to allocation of appropriated funds than to the appropriations process itself. Therefore, I have taken the liberty to forward a copy of a recent interview of me on this subject by the Disabled American Veterans Magazine. Since the substance of this interview probably more appropriately applies to some sort of oversight hearing, kindly regard it as information for your convenience rather than testimony at this time.

Respectfully,

Richard C. Adelman

Richard C. Adelman, PhD
Chairman, Geriatrics and Gerontology Advisory Committee
U.S. Department of Veterans Affairs

/rdp

INTERVIEW

A DISTINGUISHED GERONTOLOGIST DISCUSSES THE NEEDS OF AGING VETERANS

Richard C. Adelman, Ph.D.

Richard C. Adelman, Ph.D., is Chairman of the Geriatrics and Gerontology Advisory Committee to the Department of Veterans Affairs, which advises the VA Secretary and the Chief Medical Director on aging issues, including the psychological and social needs of older veterans. The 15-member committee, chartered by Congress in 1980, also examines ways to improve and expand VA Geriatric Research, Education and Clinical Centers (GRECCs), and develops models of clinical services for older veterans.

Dr. Adelman has had a distinguished career in gerontology. He has been Executive Director of Temple University's Institute on Aging, a member of the National Academy of Sciences Committee for Research on Aging, and a member of the Gerontological Society and the International Association of Gerontology. He has also served on the editorial boards of five gerontological journals, and has authored and co-authored some 80 publications on aging issues.

In this interview, Dr. Adelman discusses the needs of aging veterans, and the roles of both the VA and his committee in trying to meet those needs.

DAV: What is the makeup of the Geriatrics and Gerontology Advisory Committee, and its role in VA health care for aging veterans?

Adelman: Our committee is made up of academics, service providers, and consumers, from different parts of the country and from different walks of life. Our primary role is to bring to the attention of those who can make a difference the nature of the problems we see in geriatric care.

I think our committee has to take a reasonable share of the credit in sensitizing people to the problems, but there are many other players involved. So now, somewhat more than lip service is being paid to the problems of the aging veterans.

For the longest period of time nobody would listen, and we literally had to go to the House Veterans Affairs' Committee. Ultimately our reports are supposed to get to them, but the message wasn't being delivered, so we had to do it ourselves. I think now people are starting to listen. And they're starting to say the right things.

DAV: Some observers of the VA health care system have said that the VA, since the inception of your committee, has not developed and put into place a strategy to effectively address aging issues. Is that true?

Adelman: Historically, the VA has led the way nationally. Most of what's known about health care regarding the elderly has been developed in the VA. But in the last several years most of what's being developed is limited to a small number of centers of excellence, model programs, which are doing an excellent job. And the lessons being learned by those model programs are not being integrated into the mainstream of service delivery throughout the VA system across the country.

DAV: But you're suggesting that some positive actions have been taken recently?

Adelman: There has been some significant movement in the last few months, some of which is Congressional—appropriations for the Geriatric Research, Education and Clinical Centers. There's also a new positive image in the VA Central Office relating to older veterans, which really was not given much vocal support in the past. It seems to have gotten past a purely rhetoric stage, which is something I accused Secretary (Edward J.) Derwinski of early on.

Now the ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care seems to have a real presence in the scheme of things. People are talking about aging. There's a promise of converting a number of acute care beds to nursing home beds. It's on everybody's mind. The demographics are now accepted.

Having said all that, what's being done is really rather superficial. It's impossible to be certain whether this is step one of what will be a sincere effort to change things or whether it's fluff and not much more will happen. They've chosen to do the easy things and not to tackle the difficult things.

DAV: Who are "they" and what have they failed to do?

Adelman: Congress has failed to do what's most important. Central Office has failed to do what's most important. The hospital directors have failed to do what's most important. So have the medical establishments in most of the individual VA medical centers. We can embellish each of those points.

Starting with Congress, the single most important thing they can do is make extended care services an entitlement. I don't want to get into the issues of spending more money, of too many people being eligible. Political decisions can adjust that so the resources that the VA must live with are set at a certain level.

Whatever the political reality, whatever the limit of resources, the most rapidly growing portion of the population is being prevented access in a major way to services that they desperately need for the very practical reason that in the days of budget crunching it's going to be those services that are not mandated that get the axe. And those services that don't get mandated are the ones that are most blatantly missing from what the elderly need at the moment. It's not all that they need but it's a major piece.

Congressionally, it's nice that they finally decided to appropriate funds for three more GRECCs, bringing the total to 15, even though 25 was authorized not too long ago. I don't want to say that's not appreciated, but the impact of those three more GRECCs is almost negligible next to the far more meaningful action they could have taken, namely mandated entitlement for extended care.

DAV: What else needs to be done?

Adelman: If you look at Central Office and ask what more could be done, we're certainly not going to generate enough geriatricians to care for all the older veterans. We're not going to displace all those other health-care providers at the cost of creating a whole new cadre of people who are trained in geriatrics.

However, there needs to be some degree of training so that people in the field and people at Central Office in a legitimate practical and scholarly way are aware of the issues in modern geriatrics. These kinds of educational issues are largely not taking place.

DAV: Specifically, what kind of training and people are you talking about?

THE MOST RAPIDLY GROWING PORTION OF THE POPULATION IS BEING PREVENTED ACCESS IN A MAJOR WAY TO SERVICES THAT THEY DESPERATELY NEED

Adelman: They range from various ACMDs and their key staff in Central Office on one extreme to hospital directors and movers and shakers within each of the VA medical centers on the other extreme. Physicians need additional training, nurses need additional training—not that they need to become geriatricians rather than what their speciality is, but so that they're aware of what the problems are, who they need to consult, and not to take this God-awful attitude that since we're treating elderly people we're doing geriatrics. It's more complicated than that. We're talking about exporting that knowledge to the field.

DAV: Are you saying that people out in the field aren't aware of what needs to be done to effectively meet the needs of aging veterans?

Adelman: The GRECCs are doing a wonderful job in a small portion of those few hospitals in which they are located. Yet, in our site visits there are still hospital directors at those stations that have GRECCs who don't have the slightest idea what's going on, or what the problems of aging are.

The GRECCs are responsible for a good deal of continuing education in their regions. That's happening. But I see no evidence that the system of VA health care is becoming educated at a level so that the ACMD for Academic Affairs and the ACMD for Research and Development know that things must be done.

Let's pick on research. For example, proposals from around the country on research issues are not being evaluated by people with credentials in aging. That's ludicrous when individuals within the research office go on record publicly that there're no qualified individuals in the gerontological research community that are good enough to sit on our Merit Review Board and evaluate proposals on aging. At the same time there is a National Institute on Aging that has two or three study sections filled with these very people.

So the education isn't happening at a serious level, and research proposals are not being evaluated by people with credentials in the field. If the Secretary or his deputy or if the Chief Medical Director were to say we've got to do such and such, then it would happen.

At our last meeting, one of (Chief Medical Director) Holsinger's deputies asked if there was something he could do for us immediately. I accepted the challenge and raised this researching issue on the spot. And he said he would deal with it. That was last spring. Nothing has happened. It's routine VA speed, so I'm not necessarily shocked. But there's been no action.

DAV: What do you think causes this inaction or delayed action?

Adelman: Some say there are competing interests that I must deal with. But that's a political answer. And it's an inappropriate political answer because the spinal cord injured vet, the blind vet, the diabetic vet are all growing older and their initial complications are being worsened by age. Until the people that care for them know what that means, then they're not going to be cared for properly.

We're not saying take money away from this problem and that problem, but somehow design a system that's sensitive to the fact that aging is impacting the entire system that exists. Nobody's doing that. With

INTERVIEW

RICHARD C. ADELMAN Ph.D.
CHAIRMAN
GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

all due respect, the ACMD for Geriatrics and Extended Care is making an effort that did not exist before. I don't want to be quoted as saying nothing is happening. But it's not enough.

DAV: Why isn't more being done?

Adelman: Because the people who control the resources and the care feel that the mere presence of the elderly represents geriatrics. They're just impervious to modern tenets of geriatric health care, with a few exceptions.

This is not strictly a nursing home issue. As any practicing geriatrician would tell you, acute care is as important to the elderly as extended care, but the acute care is very different than the acute care practiced on people who are very young. The folks who are doing this are not aware of the problems in geriatrics medicine, the appropriate diagnoses, treatments, and preventative actions. The system is not adapting to the demographic reality.

DAV: What about the VA's Commission on the Future Structure of Veterans Health Care? Isn't that group adequately addressing the needs of the older veteran?

Adelman: I hope so. But I think the jury's still out. We have to wait and see what their report says. That's a while down the road, and change has been coming along like a freight train. And no one is caring for the elderly people now in an appropriate manner.

DAV: Is it a question of money?

Adelman: There isn't a great need to ask for new money. The issue is a reorientation of the mindset and the reallocation of existing resources to reflect the needs of the existing population. That means turf combat. That's what the problem is.

If this chief of medicine and this chief of surgery have this many resources, control of this many beds, they don't want to be told it should be different just because the demographics are changing. So who tells those people who provide the services where the beds should be? Who controls the people giving the care? Shouldn't the hospital director be able to make that decision?

DAV: What can aged veterans expect as far as treatment from the VA? Should they expect to be admitted to a nursing home, a Geriatrics Evaluation Unit, or some community-based centers?

Adelman: If the growing population is older and older, it seems to me you want to adjust to the changing needs of that older population, not sacrifice everything else. There should be a shift in service delivery that reflects more what the real needs are. If you're so resource intensive that you have to have a smaller eligible pool, what's wrong with that? That's just reality.

DAV: Do you see an increased demand on the VA health care system by elderly veterans? With changes in Medicare and Medicaid, will more veterans be coming to the VA as their safety net, their last resort?

Adelman: I suppose that will be true with the economic climate. There are some who will make the argument that the problem will go away, because that age group is going to pass through. What will we do with all the new resources that are devoted to them? When in reality the rest of the population at large is about to go through the same kind of changes.

This provides such an incredible opportunity for the VA and other parts of the national health care system, to integrate their efforts. So that it's no longer a VA problem but a community-based problem with non-veterans. Responsibilities and fiscal commitments can shift. I don't see any reason why they should be built into the system.

DAV: Is the VA position right now to be able to offer the aged veteran the best services they can through the most variety of services they can?

Adelman: I think most people in the VA believe they're already doing that—we're treating so many older people and that's all there is to it.

I suspect most of the services that are necessary are already there. The problem is they're not available in a manner that reflects the nature of the population. If a growing piece of the population reflects a distribution of acute care or extended care that is not characteristic of that distribution today, and that is indeed the case, then people are not going to receive appropriate care.

Even within the realm of acute care, if the kind of acute care that is needed for older people is different than it is for younger people, and it is, and there are more older people now than there were previously, there needs to be a change that reflects a redistribution of acute care services. It's not happening. The service units are there, but they have to be more sensitive to what the geriatrics issues are, and more able to deliver a different variety of services.

DAV: Do you see a greater role for the affiliated medical and nursing schools in treating the older veterans population?

Adelman: I think no one in the VA will argue that the affiliation with medical schools probably has had the single greatest positive impact on the quality of health care in the history of the VA. Given that, and given the reality that as people age they need a greater proportion of care from the allied health professionals, doesn't it make sense that the same kind of affiliation which characterizes VA medical schools should apply to VA nursing schools, and social workers, and so forth? The answer you get from the physician is "I have nurses working for me and social workers working for me."

But do you have nurse colleagues and social worker colleagues who are able to make decisions as an equal rather than as an employee? I can envision situations in caring for the elderly when there's no need for a physician to be the head of a multidisciplinary care-providing team. But that is heresy in medical circles, as you can well imagine.

DAV: Should we be looking more toward the model of rehabilitation as opposed to warehousing?

Adelman: The likelihood of rehabilitation is becoming more and more probable now with older people than it has been in the past. So in that sense, yes, the concept ought to be expanded. But in order to do that, you need new facilities. And I think it would be criminal of the VA and wrong of Congress to give the VA new resources for new facilities unless it was some how tied-in to sharing with other agencies, other community-based resources. I think everyone is aware of that problem but no one wants to deal with it.

DAV: How will geriatrics play out in the VA health-care system?

Adelman: Somebody up high has to make a very important decision. I suspect what the VA does with the elderly will in large part determine the fate of elderly in general. After all, the aging veteran is really at the forefront. The population of older veterans is aging more rapidly than the population as a whole. Quite traditionally, from the time of the Revolutionary War the VA has taken the lead.

I fear that politics and economic constraints may lead to continued indecision. No one's making the wrong decisions, there just not dealing with the problems. They're really putting band-aids in the form of three new GRECCs or 500 new nursing-home beds, which have to be labeled well-intentioned. But this does not remotely reflect the courage and decisiveness needed to change things. Somebody's got to be willing to take the flak and say the system has to be shaken up.

BAYLOR
COLLEGE OF
MEDICINE

One Baylor Plaza
Houston, Texas 77030

William T. Butler, M.D.
President
(713) 798-4846

February 14, 1991

The Honorable G. V. (Sonny) Montgomery
Chairman
Committee on Veterans' Affairs
U. S. House of Representatives
336 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Montgomery:

I am pleased to respond to your request to submit testimony to the Committee on Veterans' Affairs regarding the 1992 budget for the Department of Veterans' Affairs.

As you know from my prior testimony on numerous occasions on behalf of the Special Medical Advisory Group (SMAG), SMAG strongly endorses full support for the medical services and research programs of the Department of Veterans' Affairs. This is particularly important as, once again, we find ourselves in a time of national conflict which will increase demands on the Department of Veterans' Affairs.

Thank you for this opportunity to present to the Committee on Veterans' Affairs on behalf of SMAG.

Respectfully,

Bill Butler

William T. Butler, M.D.
Chairman
Special Medical Advisory Group
Department of Veterans' Affairs

WTB:hd

Enclosure

STATEMENT OF

WILLIAM T. BUTLER, M.D.
PRESIDENT
BAYLOR COLLEGE AND MEDICINE

AND

CHAIRMAN
SPECIAL MEDICAL ADVISORY GROUP
DEPARTMENT OF VETERANS' AFFAIRS

BEFORE THE

COMMITTEE OF VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

REGARDING

THE PRESIDENT'S FISCAL YEAR 1992 BUDGET RECOMMENDATIONS
FOR VETERANS' BENEFITS AND SERVICES

FEBRUARY 20, 1991

Mr. Chairman and Members of the Committee:

My name is William T. Butler, M.D. I am President of Baylor College of Medicine in Houston. At this time I also serve as Chairman of the Department of Veterans' Affairs' Special Medical Advisory Group. The Advisory Group was created by Congress in 1946 to advise the Secretary and the Chief Medical Director on the care and treatment of veterans.

I appreciate the opportunity to present my views on the medical care and research portions of the President's Fiscal Year 1992 budget recommendations for veterans' benefits and services.

The health care system of the Department of Veterans' Affairs has traditionally provided a foundation of security for those who serve in our nation's armed services. This system became symbolic, particularly in the years after World War II, of our public commitment to assuring the men and women who risked their lives, and often sacrificed their health and physical well-being, that they would be remembered and their needs provided for in the years that followed.

With U.S. forces deployed in the Persian Gulf, there is strong public support for providing health care second to none following their service. The VA health care system is also a vital resource for treating active duty personnel that may be injured during hostilities in that region.

Mr. Chairman, you are to be commended for your foresight in leading the way to these arrangements by enacting PL 97-174. The country will be well served by having VA hospitals involved and assisted by the considerable resources of the nation's medical schools and affiliated hospitals to treat war casualties.

While meeting these current needs, we must not lose sight of the coming challenge of an aging World War II and Korean War veteran population.

Most of our nation's largest group of veterans, those who served in World War II and the Korean War, passed the age of 65 during the 1980s. Within the next 10 years we will have nearly nine million veterans 65 or older. This will present the most severe strain ever exerted on the VA health care system, since those in this older age category require more medical care than younger veterans.

There are also new requirements within the VA medical services, such as the growing burden that AIDS has placed on the clinics and which is projected to grow at alarming rates in the years ahead. The increasing numbers of women in our armed forces is adding a growing need in gynecological services. We must be mindful of these growing needs and maintain the resources and the flexibility to meet them.

The VA health care system has earned a reputation as a stable, dependable national resource that provides medical services of the highest quality to service-disabled veterans and to veterans who cannot afford privately financed medical services. The VA health care system is also recognized as a vital component to the national academic medical program. About 100,000 health care trainees get support from the VA each year. These include medical and dental residents and students, nurses and associated health care specialists.

One-half of America's practicing physicians received some portion of their medical training through VA-sponsored academic programs.

The VA has also become an integral part of the country's biomedical research network, particularly as a living laboratory in medical innovation to meet needs of an aging veteran patient population. The VA medical staff includes many physician-scientists who are now recognized as among world authorities in such specialties as rehabilitation medicine, prosthetics and sensory aids. Their work has resulted in an increased quality of life for thousands of disabled and handicapped veterans.

The VA Geriatric Research, Education and Clinical Center Program has become a national model for geriatric medicine. The VA research programs in alcohol and drug abuse and in mental health are additional examples of the ongoing contributions to successfully addressing medical and socioeconomic problems of special concern to veterans.

Given this background, there is growing concern about the level of financial support of the VA health care system and what will happen to the quality of this national resource if its budgetary needs are not met.

The concern is especially centered on what has happened to the financing of the VA health care services in recent years.

We are pleased, therefore, that the Administration has obviously recognized that concern in this year's Fiscal Year 1992 budget request, and has included an increase of approximately $1 billion in health care funding.

Let us examine the appropriations levels of recent years and the effect on actual program levels.

In Fiscal Year 1987, the VA system's appropriation of $9.7 billion supported 194,459 full-time equivalent (FTE) medical staff. In Fiscal Year 1988, the appropriation passed the $10 billion level, but supported only 193,798 in FTE staff. In Fiscal Year 1989, the appropriation was $10.9 billion, but supported an FTE of only 191,801. In Fiscal Year 1990, the $11.4 billion appropriation supported 193,821 FTEs. In the current Fiscal Year, the $12.3 billion appropriation is intended to support 194,638 FTE.

The Fiscal Year 1992 budget request of approximately $13.3 billion submitted by the President would bring the FTE level up to 196,114. That is not much above (1,655) the number of health care personnel in the system in 1987.

This trend is certainly in the right direction, but the request doesn't fully recognize that the declining trend in recent years has had the effect of denying care in VA medical facilities to many veterans in patient Categories B and C who had previously received care in VA hospitals.

These are veterans who have come to depend on the VA system for health care. We do not know what happens to all of the patients in these categories when they do not have access to VA health care, but we can reasonably assume that they are forced to turn to state and local medical care delivery systems or that they simply go without needed health care.

There is a similar trend in VA biomedical research funding, which is only aggravated by the further reduction proposed in the Fiscal Year 1992 budget request. In Fiscal Year 1985, for example, the VA research appropriation was $192.7 million to support an FTE level of 4,551. The Fiscal Year 1991 appropriation is $216.8 million but supports an FTE staff of only 4,264.

The 1992 request is straightlined at $216.8 million, which represents an FTE level of 3,916, or a reduction of 348 research personnel. That would be a crippling blow to the VA research program.

The downward trend of the appropriation for Medical Administration and Miscellaneous Operating Expenses (MAMOE) is even more startling. In Fiscal Year 1985, the $67.9 million appropriation supported a Central Office FTE of 809. The current appropriation has dropped to $41.4 million and supports an FTE of only 528. And if my information is correct, the current FTE level includes 7 FTE and $2.8 million in support of the Commission on the Future Structure of Veterans Health Care.

The 1992 request includes MAMOE funding of $40.5 million that will support 521 FTE. The request continues support for an inadequate number of administrative personnel needed to make the VA health care system work.

Mr. Chairman, I know that this committee is well aware of the continuing staffing shortages, equipment replacement needs and other problems that have resulted from the shortage of funds within the VA health care system over the last decade.

With that knowledge at hand, I would urge the Committee to at least maintain the integrity of the VA system of medical and health care by giving favorable consideration to:

1. Providing supplemental appropriations of $200 million to meet the current fiscal year's obligations for the increased cost of drugs caused by PL 101-508 and the additional costs associated with changes to physician and dentist pay.

2. Appropriating health care funds in Fiscal Year 1992 at the requested level of $13.3 billion at the minimum, and if possible increasing the level to the $14 billion range so that services can be restored to veterans in Categories B and C who are now denied benefits.

3. Increasing the 1992 funding level for research sufficiently to meet or exceed current levels.

4. Approving sufficient funds in 1992 to improve MAMOE staffing levels.

Mr. Chairman, I believe that our citizens recognize the importance of fulfilling our obligations to the veterans who have served our country and placed their lives on the line for our nation and those throughout the world who share our common cause in freedom. I know that we share the common belief that we must make this nation's truly outstanding system of VA health care even stronger.

Especially I would like to commend you, Mr. Chairman, and members of the Veterans Affairs Committee, for your continuing support of our nation's veterans and your dedication to preserving the excellence of the health care system that serves them.

Thank you for allowing me to submit this statement on behalf of that system.

NAVAPD
NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS
3400 International Drive, N.W., Pod K-2 Washington, D.C. 20008-3098 (202) 363-3838

President
Iris F. Norstrand, M.D.
Brooklyn, NY

Vice President
Samuel V. Spagnolo, M.D.
Washington, DC

Secretary
Douglas B. Price, M.D.
Washington, DC

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Washington, DC

Director, Dental Affairs
John F. Burton, D.D.S.
Washington, DC

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Bronx, NY

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West Haven, CT

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Washington, DC

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Columbia, SC

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VI John Joseph McCaughan, M.D.
Memphis, TN

VII John G. Demakis, M.D.
Hines, IL

VIII Gerald K. Morley, M.D.
Minneapolis, MN

IX Edward J. Huycke, M.D.
Wichita, KS

X Robert A. Middleton, M.D.
Dallas, TX

XI Clifton R. White, Jr., M.D.
Portland, OR

XII Cyril Barnert, III, M.D.
Los Angeles, CA

REQUESTED SUBMISSION

of

WRITTEN TESTIMONY

of

PAUL W. SCHAFER, M.D., EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS (NAVAPD)

concerning

THE DEPARTMENT OF VETERANS AFFAIRS
FY 1992 BUDGET SUBMISSION

FEBRUARY 13, 1991

We appreciate this opportunity to submit our views on the FY 1992 Budget Submission of the Department of Veterans Affairs.

One's overwhelming impression after careful reading of these voluminous documents is nothing short of bewildered unreality akin to what Alice of "Alice in Wonderland" experienced when, while walking in an English garden, she tumbled down the Rabbit Hole and found herself in Never-Never-Land as a guest at the Mad Hatter's Tea Party.

OUR NATION IS AT WAR WITH IRAQ. And this is no Grenada nor Panama. This is a deployment on the scale of Viet Nam and our adversary, even after sustaining 70,000 air strikes, shows no real evidence of not wanting to engage in a bloody ground confrontation, the timing of which is being considered by President Bush and his advisors even as these words are being written. The Department of Veterans Affairs has the responsibility for care of the casualties from this conflict as hospitals of the Defense Department become overwhelmed, and thereafter to provide the health care to which they later are entitled as they become veterans. Yet not one word of this reality is to be found anywhere in these documents.

Aside from the unmentioned VA costs brought about by Operation Desert Storm, the added funds requested in this FY 1992 Submission will be insufficient to meet current services requirements and will fall far short of allowing the Department to match community standards of care.

A clear example is to be found in the proposal to increase the Special Pay of Physicians and Dentists by only $41.5 million. Over the past 18 months Congressional Hearings have produced eloquent testimony and voluminous documentation that such an amount will not allow the Department to recruit and to retain bright young men and women to serve in the Veterans Medical Program and to permit the Nation to honor its contract with its veterans. The Special Pay increase proposed by the Department would restore less than a fourth of the loss in purchasing power of our take-home pay provided by the Congress ten years ago (PL 96-330). Though it has yet to pass the necessary enabling legislation, the Congress recognized this inadequacy by appropriating an additional $40 million in FY 1991 funds for this purpose.

This glaringly illustrates that the Department does not have the provision of first-class, high-quality health care for the Nation's deserving veterans as its highest priority. By way of contrast is the reported $64,800,000.00 renovation of the DVA Central Office at 810 Vermont Avenue and the General Services Administration's $30,900,000.00 five year lease to house displaced Headquarters personnel in the fancy new 12-story Techworld Plaza at 801 Eye Street.

AMERICAN
ASSOCIATION
OF DENTAL
SCHOOLS

1625 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036

202/667-9433

STATEMENT OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

SUBMITTED FOR THE RECORD TO THE
COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

* * * * * * * * * * *

ON

DEPARTMENT OF VETERANS AFFAIRS FY 1992
HEALTH CARE AND HEALTH RESEARCH BUDGET

FEBRUARY 21, 1991

BACKGROUND

The American Association of Dental Schools (AADS) represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. We are the only national organization concerned exclusively with the needs of dental education.

AADS is pleased to have the opportunity to submit this statement expressing our views on the Health Care and Health Research Budget for the Department of Veterans Affairs (VA) in fiscal year (FY) 1992. Our comments will focus on our concerns about delivery of dental services and dental education activities in the VA. AADS supports the overall VA health care and health research budget levels recommended by the "Friends of VA Medical Care and Health Research" coalition, of which we are a member, and the FY 1992 Independent Budget Document ("A Nation's Commitment") prepared by veterans service organizations, which we endorse.

This budget is extremely important to VA-dental school affiliations and initiatives. Since 1989 the AADS Council of Deans and VA Office of Dentistry and Academic Affairs have worked on implementing a strategic plan to lead to closer interactions between the dental academic community and the VA. While all 55 U.S. dental schools are affiliated with at least one VA medical center, our goal is to explore more extensive sharing of faculty and staff, integrating residency programs, using VA continuing education programs to enhance dental school programs, and expanding the number and types of fellowships in areas such as geriatrics and health services research.

On January 28-29, 1991 there was a AADS-VA Workshop on "Dental Education in the VA System: Maximizing Opportunities" that brought together dental deans and VA medical center directors, chiefs of staff, and chiefs of dental service from 22 local sites that are interested in furthering this relationship. We expect many innovative local initiatives as a result of this workshop.

An adequate VA health care and health research budget for FY 1992 is essential if such promising initiatives are to proceed.

OVERALL BUDGET RECOMMENDATIONS- HEALTH CARE

AADS supports a FY 1992 VA health care appropriation of $14.8 billion. The Administration's request of $13.2 billion continues to move toward rebuilding the budget, but it is not enough to offset budget shortfalls from recent years that threatened relationships with all academic health centers. Furthermore, it would not provide for need enhancements in education and research as described below.

Categories of Concern:

1. Dental Outpatient Reform Initiatives

RECOMMENDATION: PASS PROVISIONS PROPOSED LAST YEAR IN S. 2100, TO AUGMENT BUDGET SAVINGS AND IMPROVE CARE

We highlight this issue for the FY 1992 budget as it presents an opportunity for small budget savings.

One of the largest problems with VA dental care is that medically adjunct dental care problems of inpatients can be treated, but this service cannot be provided to outpatients -- even where the attending physician determines that the treatment of oral health conditions is necessary to assure successful treatment of the overall medical condition. It is costlier to operate in this manner rather than to provide care in the outpatient setting to those who have oral health conditions that have an impact on their medical condition.

These changes have been supported by AADS for several years, and were endorsed by the Geriatrics and Gerontology Advisory Committee (GGAC) in its December 1987 report, "Oral Health Concerns of the Aging Veteran". In 1990, dental outpatient reforms were proposed by the Administration, and endorsed by the House and Senate Veterans' Affairs Committees, and the veterans service organizations. While there were several proposals in the Administration request that were excellent ideas but would have some increased costs (extending outpatient dental care to World War I veterans and all former POWS), S. 2100 as approved by the Senate committee included only those cost savings as described below:

> **Medically necessary care**- The provision would affect Medically Adjunct Care by amending § 612 (b) of Title 38 to allow dental care where "Medically necessary in preparation for hospital admission or for a veteran otherwise receiving care or services under this chapter." This would allow limited dental care to veterans to prepare a patient for surgery and other procedures that could be compromised by oral infections; and would authorize medically necessary outpatient dental care to veterans currently active in a VA treatment program. "Medically necessary" would include situations where oral health care affects cancer treatment or diseases such as diabetes and AIDS. CBO estimated a savings of $900,000 in 1990.[1]

It is not often that we can find a way to simultaneously improve health care services to veterans while lowering costs. Regulations will, of course, define the statutory limit of what dental care is medically necessary, building on strong existing guidelines in the profession.

Such a change will provide better care in several types of situations. Many diseases and treatments require that oral health care be provided in conjunction with medical care. For example, there are many oral complications from cancer treatments, such as mucosal inflammation, ulceration, oral candidiasis, viral and bacterial infections, dental or periodontal infections, and bleeding. While most patients need only minor oral treatment, which could most appropriately be delivered in the outpatient setting, failure to provide this care can lead to serious medical complications, and great costs. Similarly, HIV patients, because of their compromised immune system, require treatment of their oral problems so that an oral lesion or infection does not jeopardize their medical treatment. In many instances, oral infections must be addressed prior to medical treatment, and could be treated with greater savings in the outpatient setting. Thus, this change would assist in a variety of situations such as cardiovascular disorders, advanced liver diseases, joint prostheses, end stage renal disease, pulmonary disease, and rehabilitation.

2. Geriatric Initiatives

This is a critically important area of dental care, because of the complicated medical problems of the elderly and the growing elderly veteran population.

Many individuals age 65 and over are retaining their teeth. Due to this trend, it is estimated that the number of teeth at risk of dental disease in the U.S. will increase significantly, from 2.8 billion in 1975 to an estimated 5 billion in 2020. Therefore, oral health care for veterans with an emphasis on prevention should cost less than attempting to restore the oral cavity to health after dental care has been avoided or denied. Older americans who retain their teeth now experience more advanced periodontal diseases than younger adults. Good oral health is essential for adequate diet and overall well-being. Healthy teeth contribute to the patient's ability to speak clearly and communicate. Also, a poor appearance and discomfort related to the mouth and teeth may damage the patient's self-image and interaction with others.

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[1] AADS also supported the S. 2100 proposal to modify second opinion requirements by amending § 612 (b) (3) to increase from $500 to $1000 the amount that a fee basis dentist can charge without obtaining a second VA examination. This would also allow the Secretary to periodically review the cost of dental care to determine whether the dollar ceiling remains appropriate, and the ceiling may be adjusted as the Secretary determines necessary. CBO estimated a savings of $ 1.2 million in 1990.

A high priority for geriatric training should continue to be noted, including the training of dentists. VA dentists trained in geriatrics will be better able to treat the more complex oral heath care needs of this population.

AADS supports 2 critical VA programs in this area:

(1) Geriatric Fellowship Program -

RECOMMENDATION: OVERALL, AN ADDITIONAL $10,000,000 AND 160 FTES FOR RESIDENTS AND FELLOWSHIPS IN HIGH DEMAND AREAS SUCH AS GERIATRICS. THE DENTAL PROGRAM REQUIRES $400,000 FOR FUNDING OF APPROXIMATELY 10 FELLOWS.

Since 1982 the VA has operated a two year fellowship program (for dentists with specialized post-graduate training), currently at 6 VA medical centers. Most program graduates have been appointed to VA clinical or research positions. This program is a direct effort to meet a serious need for advanced geriatric training to provide a leadership cadre of dentist-geriatricians, as identified in the 2020 Report.[2]

The recommended level of funding is necessary for a proposed expansion of the 2 year dental geriatric fellowship into a 5 year research and academic fellowship in collaboration with the National Institute of Dental Research (NIDR) and the Administration on Aging. This is critical to develop an expert cadre of dentist-geriatricians. A longer, intensive training period is critical to help these individuals become national leaders in geriatric dentistry, and pursue a career that is focused on research, teaching, and treatment in this area.

The Administration budget would only allow an increase in 2 FTE positions for specialized fellows. This is not enough to allow for expansion in this and other fellowship initiatives.

(2) Geriatric Research, Education, and Clinical Centers (GRECCs) -

RECOMMENDATION: SUPPORT $12,000,000 TO FUND 4 NEW GRECCS IN FY 92, TO ACHIEVE 19 CENTERS AND MOVE CLOSER TO CONGRESSIONALLY AUTHORIZED LEVEL OF 25.

AADS has noted that dentists may participate in GRECCs, but their participation varies by location. Although each center has one or several specialized research areas, only one (San Antonio) has a specific oral health focus. To encourage oral health efforts in geriatrics, AADS urges Congress to require that all applicants for GRECC grants show evidence of efforts to conduct cooperative education and research with area dental schools.

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[2] The report on Personnel for Health Needs of the Elderly Through Year 2020 (Sept. 1987 Report to Congress published by the U.S. Dept. of Health and Human Services), identified several different levels of needed training, including a leadership cadre of dentist-geriatricians, numbering 1500 by the year 2000 and 2000 by 2020, and a need for 8000 to 12,000 dental practitioners with some advanced preparation in the clinical treatment of geriatric patients.

3. Education and Training Initiatives

RECOMMENDATION: AN ADDITIONAL $157 MILLION IS RECOMMENDED FOR EDUCATION AND TRAINING PROGRAMS (THIS INCLUDES GERIATRIC FELLOWSHIP AND HEALTH PROFESSIONS SCHOLARSHIPS PROGRAMS LISTED IN OTHER SECTIONS). SPECIFIC PROGRAM AMOUNTS ARE LISTED BELOW.

There is increasing demand for dental postdoctoral training, as 39.3 percent of dental school seniors in 1990 indicated plans to seek such advanced education immediately upon graduation. An additional 25 percent plan to seek such advanced training some time in the future. Resources in this area are critical because many dental students and graduates receive training in the VA; it is at least partially involved in the training of about 25 percent of nation's dental residents (since many programs feature a VA rotation), and directly provides 10.5 percent of all dental residencies and over 16 percent of dental general practice residencies. A majority of the VA dental residency positions are in general practice, with others in oral surgery, prosthodontics, periodontics, endodontics, oral pathology, public health, and anesthesiology.

These VA positions provide postdoctoral primary care training for dental graduates and offer the VA a source of manpower that will focus on patients with a myriad of complex oral health needs usually more severe than the general population. Many of the VA dental residency training programs focus on treating elderly patients and other individuals requiring specialized care, such as the handicapped, medically compromised, and those infected with the AIDS virus.

The Administration budget would only hold positions at last year's level. Our recommended budget is needed to allow for several initiatives described below, that are designed to meet needs of tomorrow's VA patient population.

(1) Continued Support of New Dental Research Fellowships- Last year the VA announced special dental research fellowships for 5 individuals lasting 2 years. The emphasis is on research training for dentists with limited research background, who have completed a specialty or general practice residency. The goal is to enhance research capability by developing established investigators. It is a key program to develop dental researchers in the VA, to meet needs described below in the research section.

(2) One Year Geriatric Extension to General Practice Residency Program- In contrast to the Geriatric Fellowship program, which addresses the need for a small number of highly trained academicians and researchers, this improvement is being sought to develop more general practice dental clinicians who can provide oral health care to the aging veteran population. This would be a step toward addressing the shortage of clinical geriatric training for health professionals. THE COST WOULD BE $750,000. Such an initiative might also allow for geriatric training of dental hygienists, as recommended in the 2020 Report. Dental hygienists play a major role in the care of the institutionalized elderly, and would benefit from programs allowing them to develop clinical and academic skills in geriatrics and the treatment of the medically compromised.

(3) Infectious Diseases Fellowships- The AIDS epidemic has had a tremendous impact on VA health care, including the VA dental service. Dental care is extremely important to the HIV infected because the signs of HIV infection often first appear in oral regions, and dentists are often the first diagnosticians to detect the disease. Patients can suffer from severe pain and discomfort as a result of these problems, making eating and speaking extremely difficult. These problems can contribute to further medical complications such as lung infection, pneumonia, and weight loss.

Data collected in the VA estimates that 72% of all VA AIDS patients have some type of clinical oral manifestation (46% had at least one type of periodontal disease), approximately 80% need some type of dental treatment, and approximately 63% are medically compromised. Nearly 44% of infected patients have been referred to dental service because of a dental emergency or another oral problem. Nearly 60% of all infected patients had a specific oral complaint that included pain on swallowing, bone pain around the teeth, canker sores, or intraoral bleeding.

To respond to these needs, AADS recommends the development of a dental fellowship in infectious diseases. THE COST WOULD BE $120,000. We also note the need for an increased AIDS treatment budget as recommended in the Independent Budget, to meet the complex health care needs of HIV and AIDS patients.

(4) Informatics- Given the increasing use of computer technology in VA dental health care, this is an opportune time for the VA to develop informatics fellowships in collaboration with the National Library of Medicine. These fellowships would allow dentists to acquire skills in utilizing existing and future information technology systems that help to improve health care. Fellows would explore areas such as utilizing the VA health care data base to determine how patient medical problems correlate with dental conditions, and learning how computers can assist in clinical-decision-making (such as checking on medications that may have an adverse impact on dental care, particularly in medically compromised patients). THE COST WOULD BE $120,000.

4. Health Professions Scholarship

RECOMMENDATION- VA SHOULD ASSESS NEEDS FOR USING THIS SCHOLARSHIP TO ASSIST DENTAL AND ALLIED DENTAL PERSONNEL.

We urge the committee to encourage the VA to review dental and allied dental need for this scholarship. This is especially critical given the significant decline in dental school enrollments in the last decade (described in the special pay section below). This decline, combined with high student debt and its impact on recruitment, has led the Army and Navy Dental Corps to re-activate Health Professions Scholarships for dentists in the military. AADS believes a similar need exists in the VA. Also, if an additional $5 million is provided as requested Independent budget for recruiting scarce medical specialists into the VA, we urge that this be authorized for other health professions such as dental and allied dental personnel, depending on local facility need.

5. VA Dentist Pay Initiative

RECOMMENDATION- PROVIDE ADEQUATE FUNDING FOR PROPOSED NEW PAY LEGISLATION BASED ON CURRENT HOUSE BILL PROVISIONS. REJECT LOWER ADMINISTRATION RECOMMENDATION.

AADS is concerned with the VA dentist special pay issue because dental manpower trends suggest problems with the supply of VA dentists, based on AADS surveys and those of the National Association of VA Physicians and Dentists (NAVAPD).[3] We have pointed out that if VA dental attrition increases due to retirement or inadequate pay, then there will be an increasing need for new dental recruits. Such individual dentists must be among the very best of dental school graduates as they will increasingly be called upon to train residents and conduct research at VA facilities. However, future VA dental recruitment will occur in a highly competitive environment due to significant predicted declines in dental school enrollment and the dentist-to- population ratio.

AADS has forecast future dental school enrollment and manpower trends in light of the dramatic 37 percent decline in first year enrollments since 1978, which has resulted in a declining dentist to population ratio. Also, over a 10 year period the number of dental graduates entering government service has decreased 45 percent. While enrollment and the number of graduates seeking to enter government service appears to be stabilizing, the impact of the last ten years of change means that the VA will need to compete for recruits in an ever tightening market.

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[3] There was a one day survey conducted by NAVAPD last June that estimated there were 102 VA dentist positions eliminated plus 228 VA allied dental positions eliminated in last two years.

Given these changes, the next 20 years will likely be a particularly critical period in maintaining adequate numbers of dentists. The future is likely to consist of dental under-supply. We have noted that if VA salaries do not become competitive, the future of VA dental care will be damaged.

Therefore, the budget needs to adequately address enhancements in the current House bill (H.R. 598), such as special pay ranges that have minimum dollar amounts (rather than 0), tenure pay for dentists that is divided into greater categories than in earlier legislation, and enhancements such as the $1000 reimbursement for continuing education for board-certified VA dentists (which we would urge be extended for all VA dental personnel).

6. Allied Health Care Recruitment and Retention

RECOMMENDATION: SUPPORT REAUTHORIZATION OF HEALTH MANPOWER GRANTS, AND PROVIDE ADEQUATE FUNDING.

One area of particular concern for dental education is the supply of allied dental personnel such as hygienists. Increased funding would allow the VA to study potential health profession shortage areas in the VA, and use funds to retain such personnel by offering increased salaries, continuing education, and advanced training opportunities.

AADS is concerned that personnel shortages may be developing in the areas of dental assisting and dental hygiene; our 1989 survey of VA chiefs of dental service revealed that attrition was high for dental assistants and dental hygienists due to low salary. Therefore, money to expand the health professions scholarship program and make it available to more types of health disciplines is needed as noted above. This is especially true for areas such as dental hygiene, that focuses on disease prevention.

We support the continued Independent Budget request for authorization to fund grants to VA affiliated health manpower training institutions in allied health professions where shortages exist.

7. MAMOE (Medical Administration and Miscellaneous Operating Expenses)

RECOMMENDATION- PROVIDE INCREASE OF $55.5 MILLION SO THAT CENTRAL OFFICE STAFF CAN CONTINUE ESSENTIAL FUNCTIONS.

Our continued efforts with VA-dental school affiliations will be damaged if the VA central office is further reduced. Staffing is critical for providing necessary data analysis, organizing research and training initiatives, supporting recruitment efforts, and carrying out the Congressional mandates for dental care. Reductions harm the ability to pursue valuable joint initiatives with dental schools, and diminishes the possibility of working with other federal agencies such as the National Institute of Dental Research and the National Institute on Aging. We believe it is more cost-effective to have staff in the central office providing valuable analytic and management support and focusing on the entire system. One example of the staffing support needed for data analysis is the concern over lack of data on dentist vacancies in the VA, which has led to a provision in proposed special pay legislation that calls for annual reporting from the VA on dentist vacancies. This type of analysis of the entire system cannot be accomplished without adequate central office staff.

OVERALL BUDGET RECOMMENDATIONS: HEALTH RESEARCH

To achieve the goals listed below, AADS joins the "Friends of the VA" and the Independent Budget in recommending a total appropriation of $281 million for health research in the VA.

We continue to be concerned over the low level of support for VA dental research, especially for areas such as geriatrics and AIDS. In FY 1987 only 6 percent of dental personnel in the VA system were actively pursuing research projects. In FY 1989 VA dental research received only $1.16 million in direct VA funding. Enhancing Geriatric dentistry research was recommended in the December 1987 Report of the Geriatrics and Gerontology Advisory Committee entitled "Oral Health Concerns of the Aging Veteran". This report also noted that VA dentists have not traditionally been encouraged to perform research in the VA. Our 1989 VA Dental Survey revealed that while dental research was being conducted at only 32 percent of facilities, 66 percent expressed an interest in beginning or expanding research.

VA dental research has contributed important insight in the areas of recurrent tooth decay among aging veterans, implants for those without teeth, the impact of tobacco use and diseases such as AIDS and diabetes on oral health, the oral health impact of prescription medications that many elderly take (such as developing remedies for dry mouth - decreased saliva production- and the resulting exposure to caries and infection), and the effectiveness of dental restorative materials.

The funding level we are recommending would provide the opportunity for greater activity in the dental research area, by allowing opportunities for dentists be considered for Career Development Awards, to submit proposals in areas of health services research (to examine the quality and effectiveness of different dental treatment strategies), and to conduct clinical trials in areas such as geriatrics and the impact of medical conditions on oral health. Also note that if the increased funding can be provided for residency training, these dental residents can assist in the research workload and patient care (allowing more time for VA dentists to pursue research). We also expect the recent VA-dental school workshop to lead to more ideas for joint research with dental schools and the VA. AADS urges the committee to support increases for these programs, rather than the same level from last year as the Administration requests. A funding increase will particularly encourage VA dental researchers to submit proposals, as it will allow an improved chance for funding.

Good research opportunities provide better care for veterans, career enhancement for VA dentists, and better training for VA dental residents. The value of VA research for physicians, as described in the Final Report of the Advisory Committee for Health Research Policy, is also applicable for dentists, as dental research projects are a valuable tool for the recruitment of young dentists and allied dental health personnel into the VA. Having excellent dental researchers and dental research projects in the VA results in better and more efficient care of oral health problems of the VA patient population.

CONCLUSION

AADS believes that the budget recommendations discussed above would provide the necessary level of health care and research for the nation's veteran population, while utilizing resources of the VA (in cooperation with U.S. dental schools) to provide better training opportunities for the nation's dental health professionals.

AADS thanks the committee for considering these comments.

STATEMENT
OF THE

NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY
(NAVACOP)

BEFORE THE

U. S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS AFFAIRS

ON THE
ADMINISTRATION'S FY 1992 BUDGET RECOMMENDATIONS

FOR THE

DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CARE AND HEALTH RESEARCH PROGRAMS

The National Association of VA Chiefs of Psychiatry (NAVACOP) represents the Chiefs of Psychiatry at all Department of Veterans Affairs Medical Centers with Psychiatry Services. We appreciate the opportunity to testify on the Department of Veterans Affairs Fiscal Year 1992 Budget Submission pertaining to medical care and medical research.

Over the past 10 years, the ability of the Department of Veterans Affairs to provide quality care to veterans with mental disorders, combat stress disorders, and substance dependency has been severely eroding. This deterioration has occurred at a time when American Psychiatry has made great strides in the development of new techniques in the diagnosis and treatment of these disorders. In the early 1980's, the structure for a new diagnostic system was created, which permitted more precise and accurate classification of mental disorders. Over the course of that decade new discoveries in neurobiology and the application of new diagnostic and treatment technologies benefitted millions of Americans afflicted with these devastating disorders.

Many veterans have been able to benefit from this progress in diagnosis and treatment. Psychiatry Services in our VA medical centers now treat over 20% of all inpatients and almost 20% of all outpatients. Over the last decade, inpatient treatment has been shortened from months to weeks, and the emphasis of much of this treatment has shifted from long inpatient stays to brief hospitalization, with intensive outpatient and partial hospitalization treatment.

During the past two years, Congress has demonstrated its concern for veterans suffering from combat stress disorders, substance dependency, and homelessness due to chronic mental illness by appropriating funds for programs designed to deal with these special problems. The programs developed under these auspices have enabled numerous veterans to again become functioning members of their communities.

The ability of our Medical centers to continue to respond to the needs of our veterans with these disorders is now in serious jeopardy. Over the past 5 years, psychiatrist vacancies in our medical centers has soared from six percent of authorized FTEE to over eighteen percent nationally. Attachment A shows the results of a survey of psychiatrist vacancies conducted in January of this year by NAVACOP. Data in the table show that the psychiatrist vacancy rate ranged from over fifteen percent in our medical centers that are most closely involved with medical school affiliations (strongly affiliated) to over thirty-four percent in the unaffiliated centers (those without medical school affiliations)! The effect of these high vacancy rates are unmanageable caseloads and low morale for our staff, and poor quality care and long waits for appointments for our patients.

The table in Attachment A also indicates the high turnover rate (percent of authorized FTEE becoming vacant each year) for our Psychiatry Services over the past four years. With the time required to fill vacant psychiatrist positions ranging from 1 to 4 years, marginally staffed services become even more understaffed. Work overload and poor treatment continuity results. The NAVACOP survey shows that over 80 percent of all Chiefs of our medical center Psychiatry services believe that this shortage of Psychiatrists has resulted in a marked decrease in the quality of care that our veterans receive.

Although the staff shortage is acute in our most strongly affiliated medical centers, the situation has passed crisis proportions in our unaffiliated centers. As can be seen from the figure in Attachment A, the vacancy rate in unaffiliated centers jumped from almost 25 percent in our last survey (January 1990) to over 34 percent this year! These centers have attempted to continue to treat patients by temporarily using non-psychiatrist physicians, physician assistants, and nurse practitioners. Although these substitutes help maintain workload and adequacy of care, quality psychiatric treatment cannot be delivered without quality psychiatrists.

A high priority in the Fiscal Year 1992 budget should be to appropriate sufficient funds to enable our medical centers to attract and retain high-quality physicians. In the opinion of NAVACOP, the Administration's proposed budget insufficiently addresses this problem. The primary competition for recruitment of psychiatrists for our unaffiliated medical centers are state mental health systems and institutions. Many states are now offering beginning psychiatrists twenty to forty thousand dollars per year in salary above the top salary offered by our medical centers. In our affiliated centers, we are unable to replace experienced, highly qualified psychiatrists. Many Chiefs of Psychiatry in our most strongly affiliated centers report that when a senior psychiatrist retires or resigns, they can only be replaced (with difficulty) by a psychiatrist who has just completed residency training, and who will leave the center after one or two years for much higher salaries.

The importance of available VA research funding in the recruitment and retention of psychiatrists for our affiliated medical centers should also not be understated. The figure in Attachment B demonstrates the inverse association of federally funded research with psychiatrist vacancy rates in our strongly affiliated medical centers. In adequately funding research in our VA medical centers, we can achieve immediate gains in staff retention and longer term gains in medical progress. In this regard, the Administration's budget falls far short of achieving these gains.

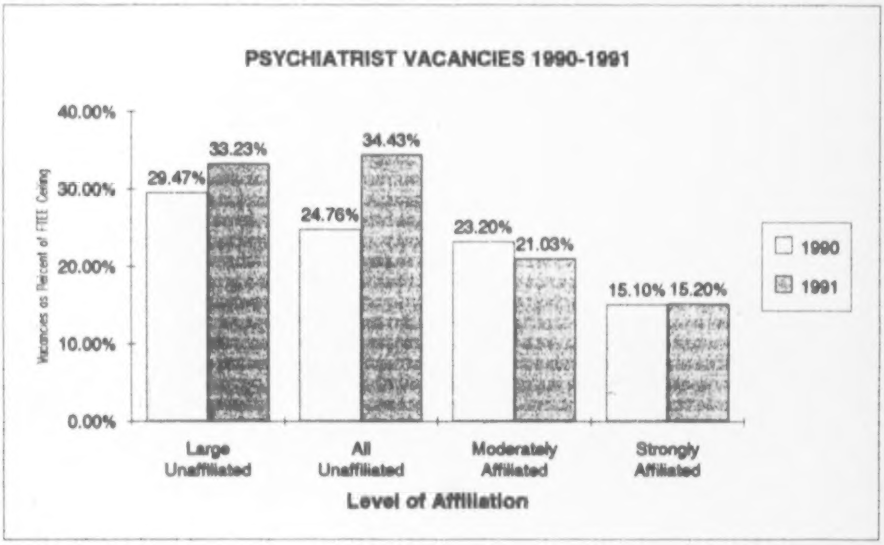
In summary, American Psychiatry now has the tools and techniques to significantly improve the care and treatment of millions of Americans with mental disorders and associated illnesses. Psychiatry programs in our VA medical centers have shown a willingness and ability to respond to our veterans' needs for these services. Our ability to respond cannot continue in the absence of sufficent high quality staff. Psychiatrist staffing levels have fallen below that necessary to maintain programs of adequate quality. Competitive pay levels and adequate VA research funding are necessary to restore our programs in order to provide treatment to veterans with mental and emotional disorders. The Administration's FY 1992 budget falls short in both of these areas. We hope that Congress will sufficiently address these shortfalls in budget legislation.

Thank you for giving us this opportunity.

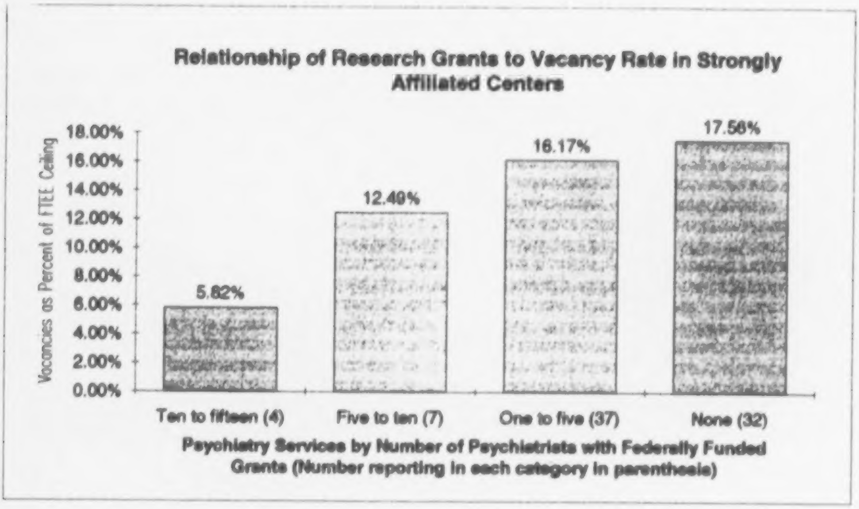
Attachment A

SURVEY OF PSYCHIATRIST VACANCIES JANUARY 1991

RESPONSE	TOTAL	LRG UNAFFIL	ALL UNAFFIL	MOD AFFIL	STRNG AFFIL
Number VAMC's responding	134	11	25	29	80
Authorized Psychiatrist FTEE	1570.13	128.8	170.8	252.525	1146.805
Number of Vacancies	286.17	42.8	58.8	53.1	174.27
PERCENT VACANCIES	**18.19%**	**33.23%**	**34.43%**	**21.03%**	**15.20%**
Turnover Rate per Year	14.93%	17.13%	16.30%	19.68%	12.75%
Temporaries viced against MD's	105.6	21	26	31.5	48.1
% of FTEE filled with temporaries	6.71%	16.30%	15.22%	12.47%	4.19%
No. Beds Closed to Admissions	1301	375	477	405	419
% Beds Closed to Admissions	7.19%	13.68%	14.52%	10.42%	3.85%
Decreased Quality of Care	80.74%	90.91%	80.00%	89.66%	78.75%



Attachment B



Centers are grouped by number of Psychiatrists holding federally funded research grants. Numbers in parenthesis indicate the number of centers represented in each grouping.

NOVA NURSES ORGANIZATION OF VETERANS AFFAIRS
1341 G Street, N.W., Suite 1100
Washington, D.C. 20005
Phone (202) 347-4483

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Palo Alto VAMC

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Brooklyn VAMC

STAFF

Executive Director
JULIA T. SUSMAN

February 28, 1991

The Honorable G.V. (Sonny) Montgomery
Chairman
Committee on Veterans' Affairs
335 Cannon
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Attached is Noreen Sommer's statement to be included in the record of the Committee Budget Hearing. Thank you for the opportunity to present NOVA's views on the FY '92 proposed VA medical care budget.

Sincerely,

Julia T. Susman

Julia T. Susman
Executive Director

Enclosure

Mr. Chairman and Members of the Committee, The Nurses Organization of Veterans Affairs (NOVA), views health care as an important and most basic need for our nation's veterans. We wish to address the funding needed by the 172 VA Hospitals and 200 Outpatient Clinics to ensure that veterans needing health care, receive quality care in a timely manner. VA nurses are in the forefront in programs caring for veterans in the full continuum of acute and long term hospital care, as well as nursing home care, ambulatory care and home care.

NOVA was gratified to see that the Administration has indicated a commitment to veteran health care by presenting a budget that includes an increase of $974 million over last year. Unfortunately the Administration's 1992 budget proposal will only slow down the current funding crisis. Veterans' health care needs will continue to be unmet as the 700 to 800 million dollar shortfall that began in 1988 is passed down every year. This budget will do nothing to replace the $1 billion of worn out medical equipment and the aging physical plants. The increase of 1,476 personnel to a total of 196,114 is largely to support facility activation and will do little to relieve the existing shortages of personnel. External reviews of the quality of care will do little to improve care if the are no provisions to ensure that the proper environment, sufficient resources, and sufficient qualified staff are in place to provide care.

Years of continual inadequate funding with alterations in eligibility and access to veteran health care arouse concern for the VA system's continued viability. There is a need for VA to define its present, as well as future objectives and to develop a strategic plan to meet those objectives with sufficient resources for personnel, physical plants, equipment and technology, innovative health care delivery processes and programs. Veteran eligibility guidelines need to take into consideration the modern medical reality that many services are best provided on an outpatient basis. One of NOVA's priorities is that outpatient services and a continuum of comprehensive services are available for all patients who are eligible for hospitalization. This includes the support of health promotion and preventive interventions as cost effective measures for reducing acute care utilization. The VA as a health care provider should mandate complete and comprehensive care of a patient. It makes no sense to rehabilitate a patient with the latest prosthetic devices so he can walk and deny him glasses to see where he's going. It makes no sense to perform surgery or provide state of the art medical treatment for an acute episode of illness and fail to manage a chronic physical or mental illness, or in the case of many veterans both chronic physical and mental illness.

The VA health care system experiences a situation similar to that of the American health care system as it faces increased health care expenditures due to more modern technology and increased longevity of the population served. While we are aware that reaching age 65 or any particular age does not mean immediate ill health, the data show that increasing age increases the percentage of those with impaired ability to conduct activities of daily living or to perform basic functions that support those activities. Recent data from HCFA indicate that at age 65-69 the percentage of impaired persons is 12.6% , reaching 35.4% by age 80-84 and 55.3% for those 85 and over. VA data confirm this when nursing home use by veterans 85 and older is 20 times that by veterans 55-65.

The increased degree of impairment for increasing numbers of aged veterans increases the number who will not be able to remain at home due to lack of an adequate support system or because the needs are so great institutional care is indicated. HCFA data supports this position showing that 1% of persons 65-74 are in nursing homes and 22% of persons aged 85 and over are in nursing homes. VA will need to provide care either in converted general hospital beds for the geriatric or in skilled nursing care facilities. Hospital capacity needs to be sufficient to ensure that eligible veterans who seek care will have access to high quality care appropriate to their medical condition, social situation and age. There is increased use by older individuals of acute hospitalization and critical care. National health data show that American men 65 and over have 2 times the number of hospital stays per capita than do men in the 45 to 65 age group. VA hospital data show that the utilization peaks in the frail elderly over age 75.

As the VA is expected to provide services to meet the needs of the Persian War theater as well as veterans of armed hostilities such as Granada or Panama, the dollars to pay for these services must be included. We must strive for generational equity as we provide services. Health care providers should not have to choose between the the generations of past warriors and a new generation seeking services for the first time.

Past inadequate VA appropriations have jeopardized the quality and quantity of VA health care. Funding for VA health care must remain a priority, if we are to fulfill our obligations to our nation's veterans. Less money means restricted care which means patients do not receive the care they need. When needed medical or psychiatric treatment is delayed or compromised, patients become more acutely ill and require more costly emergency care. Hospital stays are often prolonged and rehabilitation is less effective due to additional problems or complications arising from delays or restrictions.

NOVA asserts that the inadequate medical care budgets of the past have had an adverse impact on the ability of the VA to recruit and retain adequate numbers of VA nurses. Competition for registered nurses exists, and VA is unable to compete for this scarce, needed professional resource. The shortage of registered nurses is serious at a time of increased patient acuity. While the nurse shortage is not unique to the VA, studies have shown that resolution of the shortage will depend on competitive pay, a good working environment, and educational opportunities. Nursing is not the only area where there are shortages. There are shortages in other departments and nurses are required to fill in the gaps as respiratory therapists, blood drawers, ward secretaries and housekeepers. This situation has worsened with the call to active duty of 893 nurses during the Persian Gulf Crisis.

The continuous restraints of the budget have also resulted in the low nursing staff to patient ratio and the requirement of shift rotation by a large majority of VA nursing staff. Studies of VA nurses over the past 20 years have all revealed a problem with shift rotation. According to the Klemm report the requirement of shift rotation by VA, while other hospitals do not, may be the one significant item that distinguishes the VA work environment from its competitors. NOVA was hopeful last year when an effort was made to reduce shift rotation with a pilot program that increased 798 positions in 26 hospitals. There was the hope that this was a step in the right direction and that the inadequate nurse to patient staffing ratio would one day be corrected. The

Association of American Medical Colleges reports: "Despite having more total beds and similar numbers of acute care beds, when compared to nonfederal teaching hospitals, VA hospitals have fewer personnel. The average VA teaching hospital has 2.9 full-time equivalent personnel per bed as compared to 4.6 in the average nonfederal teaching hospital." Unfortunately this budget contains no support for increased nursing positions. Funding is needed for an additional 4800 nursing FTE to assure appropriate staffing levels.

VA nurses report that the Unit Dose Program, which increases the efficiency and accuracy of medication administration to patients, has not been implemented in the area in which they work. Lack of money is always blamed for failure to accomplish this beneficial program.

NOVA is pleased to see the inclusion of approximately 10.1 million dollars for health professional scholarships in the budget. These scholarships have resulted in over 750 nurses currently working for VA under scholarship obligation. The scholarship program enhances VA's ability to recruit qualified registered nurses and keep them long enough to commit to a career as a VA nurse.

In conclusion, VA health care policy, programs and services are driven by budget policy. NOVA urges you to carefully examine the Administration's budget proposal to ensure balance between fiscal caution and quality health care. It is important to support the effort the President's budget makes to begin to improve veteran health care but also, to identify and revise the areas in which the budget is inadequate and undermines the VA's mission. We also commend and endorse the **Fiscal Year 1992 Independent Budget for Veterans Affairs,** and urge the committee to consider the intelligent and perceptive approach to the funding of VA medical care reflected in this document.

Thank you for the opportunity to present this statement.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

AMVETS
National Headquarters
4647 Forbes Boulevard, Lanham, Maryland 20706-9961
(301) 459-9600

March 4, 1991

The Honorable G. V. Montgomery
Chairman
House Veterans Affairs Committee
335 Cannon House Office Building
Washington, DC 20515-6335

Dear Chairman Montgomery:

In response to your request of February 21, 1991 wherein you requested that AMVETS provide the full committee with additional information/answers in conjunction with the recent budget hearings, we offer the following.

Questions 1 and 2 in your letter will be answered and forwarded to your office under separate cover as they are directly related to the Independent Budget.

Question 3, however, is not an issue that was addressed by the IB and we are, therefore, responding to this question as an individual veterans service organization and not as a participant in the Independent Budget process. Question, "If you were to reform the DIC program, what type of formula would you suggest be used to attain equity?" First and foremost, to attain equity, one would first have to decide how much a human life is worth. Once this was established, equity would ultimately follow.

Mr. Chairman, while AMVETS has debated this issue many times in many different forms, the only concrete and mutually agreed upon consensus is that the current system is simply unjust. When you consider that most battlefield deaths equate directly to the young, low-ranking enlisted men who will never have a chance for promotion nor the opportunity to climb the social strata after service, it is painfully obvious that the current system is anything but equitable.

The current system implies to the young widows and orphans that had their husbands/fathers not given the ultimate sacrifice for their country they would have achieved very little success had they lived. On the other end of the spectrum we find the high-ranking officer who, through longevity, was able to achieve financial security and the social status attributed thereto. Once again, it becomes obvious that the loss of the income generating potential of this type individual may be devastating to a surviving dependent. Thus, we immediately encounter a number of scenarios in an attempt to decipher just what is fair or equitable.

DIC, as we know, does not relate just to those who lost their lives while on active duty. We must also consider those who are disabled

American Veterans of World War II, Korea and Vietnam

and whose disabilities subsequently are directly attributed to their death. Is it equitable to assume that a private who survives his battle injuries will not achieve, for his family, the same level of financial security and social status of a senior enlisted person or a general officer? Under the current system an individual could be medically separated from the armed forces as a private and become extremely successful only to expire some years later directly the result of his service injuries at which time his survivors would be compensated as though nothing transpired in the interim.

Another area that must be considered with any attempt to review DIC payments is how any proposed changes would affect service-connected veterans and their current status with respect to the Survivor Benefit Program. Many 100 percent service connected veterans have opted to cancel their SBP as current law provides for entitlement to DIC. Therefore, care must be taken to ensure these survivors are not faced with a large scale loss of income.

It is worth noting that when establishing disability compensation rates, a table of lost earning capabilities was factored in so that the loss of an arm was the same loss to both a general or a private. We find it interesting that the loss of life is compensated on the highest rate attained thus, targeting longevity within the military with no consideration given to an early demise because of military service.

In answer to the question posed, AMVETS does not, at this time, have a formula that we could suggest in an effort to achieve equity in the realm of DIC. We are able to tell you that we are not in agreement with the administration's proposed level of pay grade E6 as a basis for all future entitlements. Further, any proposal must include adequate safeguards for those veterans currently receiving service-connected disability as well as those survivors currently in receipt of DIC. Any attempt to standardize DIC payments should, at a minimum, equate to pay grade E8 with the assumption that an annual cost of living allowance would be included.

In closing we are in hopes that we will be able to work closely with the committee as you move forward in an attempt to resolve this long-standing inequity.

Sincerely,

Noel C Woosley

Noel C. Woosley
National Service Director

NCW/kw

March 13, 1991

Honorable G. V. Sonny Montgomery
Chairman
House Veterans Affairs Committee
United States House of Representatives
335 Cannon House Office Building
Washington, DC 20515-6335

Dear Chairman Montgomery:

As requested in your letter of February 25, 1991, the following is our response to questions posed to DAV by Ranking Minority Member Bob Stump.

There are approximately $2 billion more in your proposed budget than in the Administration's proposal. Given the spending caps we are facing, the extra $2 billion may not be achievable.

(1) Would you spend the $13.7 billion for health care differently than the Administration?

The short answer is no but, as is usually the case, the short answer requires some explanation.

The requested $13.7 billion for medical programs falls $700 million short of the amount the Independent Budget (IB) calculates is needed to maintain a current services budgetary level, using the FY 1988 level of VA medical programs services as a constant baseline. As you know, both the need and demand for veterans' health care services has significantly increased since FY 1988.

For medical care, the Administration has requested $13.3 billion for FY 1992, an increase of $976 million over FY 1991. Nonetheless, this is a decremental budget request because $14 billion would be needed for FY 1992 just to maintain medical care services at the FY 1988 level. I refer you to the IB, p. 82, Table 20 for a breakdown of the VSOs' FY 1992 current services calculation.

It is important to emphasize that approximately 88 percent of the $976 million increase for medical care requested by the Administration for FY 1992 is planned to be spent for purposes that have little, if any, direct meaningful impact on disabled veterans. For example, $581 million is earmarked specifically for increased payroll costs for existing employees and $280 million is earmarked for increased costs, other than personnel, due solely to inflationary factors.

To put the situation clearly in context, except for domiciliary care, the VA is providing health care services to fewer veterans in all modes of health care delivery than it was providing in FY 1988 (see the IB, p. 75, Table 19). This has occurred despite growing unmet needs for veterans' health care.

The fact is that the Administration's requested medical care appropriations is insufficient to pay for many necessities. In our view, it is pointless to prioritize or differentiate among necessities. The requested $13.3 billion for medical care will have to be spent on bare-bone essentials and, this being so, choosing among spending alternatives is much like a destitute man deciding to spend what little he has on food, clothing, or shelter. Pursuing the analogy, VA has chosen to allocate an inadequate budget request for inadequate amounts of food, clothing and shelter. Given the limited requested budgeting authority, we cannot disagree with those choices.

Obviously, the Administration's budget request is simply not enough to even pay for the essentials of veterans' health care. This, of course, is the message the VSOs have been conveying for several years in the IB. What this means is that VAMC Directors constantly must make choices between, for example, spending for badly needed equipment maintenance and purchases or direct patient care staff. This is why veterans must wait 3-4 months for an outpatient clinic appointment and 9 months for some specialty clinic appointments. And this is why there are no funds to implement more medically appropriate and cost-effective treatment and care modalities, such as ambulatory care and extended and non-institutional care.

This is the framework in which the IB recommended FY 1992 medical care appropriations of $14.9 billion should be considered. This is an increase of $1.6 billion over the Administration's FY 1992 request. Because funding for a current services level alone requires $14 billion in appropriations, the Administration's medical care appropriation request of $13.3 billion makes spending choices a moot issue. Unless $700 million more than the Administration requested is provided, VA will not be able to deliver health care services to veterans at the FY 1988 level.

With adequate medical care funding, there are definite spending choices. Priority should be given to shifting away from inpatient care to more appropriate and efficient delivery settings. The IB workload targets include a relatively stable inpatient average daily census but significant increases in ambulatory outpatient visits and available extended care and non-institutional care to meet the needs of veterans, especially the rapidly growing number of aged veterans. There is little doubt that this is the direction VA should and must take; however, it is powerless to do so with the funding level the Administration requested for FY 1992.

(2) What do you suggest as sources of the additional $2 billion recommended in the Independent Budget?

It has been our position that veterans health care and nonmedical benefits and services as well as their timely and efficient delivery should be one of the nation's highest priorities. Operation Desert Storm certainly brings this into focus. When the nation sets priorities or has them set by crises such as the Savings and Loan fiasco, the Administration and Congress do not ask where the money to pay for them will be found before action is taken. They take action and find ways, usually very innovative ones, to pay for them. Funding to go to war in the Persian Gulf was not a prerequisite for the decision to do so. A pay-as-you-go requirement for war would certainly be a case of the "tail wagging the dog."

We strongly believe that veterans' health care and benefits are an ongoing price of war (and peace) and therefore should be treated as a national priority that the Administration and Congress should find a way to fund adequately. Within a $1.45 trillion federal budget which, among other things, includes an endless litany of dubious pork-based projects and grants, the Administration and Congress certainly have the ingenuity to find the additional $2 billion needed to adequately deliver veterans' authorized health care and benefits programs. To state it simply: if the political will were present to provide veterans with adequate health care and benefits, funding to do so would be found easily. We have some specific suggestions for possible funding sources.

The simplest and quickest solution is to view adequate VA funding as an adjunct of Operation Desert Storm. The costs of Operation Desert Storm are, of course, "off-budget." However, the Administration, with the concurrence of Congress, has requested and received to date commitments of approximately $50 billion from our allies to contribute toward defraying the costs of Operation Desert Storm. In particular, the Japanese government has agreed to contribute $10.7 billion with the proviso that it be used for non-lethal, humanitarian purposes relating to the war effort.

We cannot think of a more humanitarian but war-related use for $2 billion of these funds than to provide VA with the resources needed to deliver adequate health care and benefits to veterans who, to use the words of President Bush, have done "the hard work of freedom." This, we think, would have enormous bipartisan political appeal and would enable Congress to repeal the Omnibus Budget Reconciliation Act of 1990 (OBRA) veterans' benefits entitlement cuts and finally permit VA to provide the level of health care and benefit and service delivery that veterans deserve and we all want.

Another major attraction of this proposal is that it could be accomplished quickly and simply outside of the "normal" budget process.

Another alternative source for the $2 billion is the VSO plan for deficit reduction, which is fully described in the FY 1992 IB (see pages 47-55 of the IB). The plan would not only repeal OBRA's entitlement cuts but would produce deficit reduction savings substantially exceeding OBRA's deficit reduction targets. We believe that these excess savings can and should be retained for VA's use and that this is permitted under both the letter and spirit of OBRA's Budget Enforcement Act (Title XIII).

Another significant revenue source can be found in OBRA's Title XIV, which includes the Majority leadership's commitment to enact an additional $500 million in appropriations for veterans' programs by FY 1993.

In short, with political will, leadership, and creativity, revenue sources for adequate VA funding can be found.

3) **You have included in your budget approximately 143 million dollars in reimbursements. Is there a similar category in the Administration's budget? What is the basis for these reimbursement figures?**

Reimbursement figures are taken directly from the VA's FY 1992 budget request. Reimbursements to the Veterans Benefits Administration (VBA) are now a significant funding source for its operation. Reimbursements are amounts received from other federal sources and within VA itself.

Provisions of OBRA have greatly increased the amount of reimbursements to VBA. In FY 1990, for example, VBA received $4.1 million in reimbursements but in FY 1991 it will receive $25.3 million and in FY 1992 it will receive $142.7 million in reimbursements (see FY 1992 VA budget request, Vol. 4, p. 24-16). The increase in FY 1991 is directly related to OBRA provisions that authorize reimbursements from "amounts available to the Department of Veterans Affairs for the payment of compensation and pension" to pay for the administrative costs of implementing OBRA's deficit reduction provisions by VBA staff. This, of course, involves transfers from mandatory entitlement accounts (compensation and pension) to discretionary (General Operating Expenses) accounts.

During FY 1991, the increased reimbursements will support 508 additional FTEEs, however, these FTEEs are earmarked solely to implement deficit reduction provisions (see Vol. 4, p. 24-18).

The credit reform provisions of OBRA are effective beginning in FY 1992 and they have a major impact on the Loan Guaranty component of VBA (and, to a lesser extent, on other VBA components). As required by the Federal Credit Reform Act of 1990 (P.L. 101-508), funding for the administrative costs of the Home Loan Program will be reimbursed to the General Operating Expenses appropriation from the Loan Guaranty Housing (entitlement) appropriation.

For FY 1992, OBRA-related reimbursements will amount to $9,711,000 and Credit Reform reimbursements will amount to $128,170,000. These account for $137,881,000 of the total FY 1992 VBA reimbursements of $142,721,000.

The significance of reimbursements is that they reduce, dollar-for-dollar, the amount of VBA's appropriations request. To be sure, appropriations are nonetheless necessary for these administrative activities but they come in the form of transfers from mandatory entitlement accounts.

4) If you were to reform the DIC program, what type of formula would you suggest be used to attain equity?

DAV has long sought a change in the current rank-based payment formula in the VA's DIC program -- currently comprised of some 25 different payment amounts. It is our belief that payments to survivors of service-connected disabled veterans based upon the military rank of a veteran is inherently unfair and does not reflect the true financial needs of veterans' survivors.

Any new DIC payment formula, whether it be one standard rate or at the most three or four different rates, should take into consideration the degree of a veteran's disability at the time of death.

Additionally, survivors of service-connected disabled veterans should receive the highest payment.

Sincerely,

JOHN F. HEILMAN
National Legislative Director

JFH:py

RESPONSES TO POST HEARING QUESTIONS SUBMITTED TO THE VFW BY THE HONORABLE BOB STUMP:

THERE ARE APPROXIMATELY 2 BILLION DOLLARS MORE IN YOUR PROPOSED BUDGET THAN IN THE ADMINISTRATION'S PROPOSAL. GIVEN THE SPENDING CAPS WE ARE FACING, THE EXTRA 2 BILLION MAY NOT BE ACHIEVABLE.

Question (1)

WOULD YOU SPEND THE $13.7 BILLION FOR HEALTH CARE DIFFERENTLY THAN THE ADMINISTRATION?

VFW RESPONSE

In our estimation the current fiscal vice in which the Department of Veterans Affairs finds itself entrapped will allow for no course of action other than the maintenance of current programs. After inflation, mandated pay raises, and other automatic cost increases are taken into consideration, the Administration's VA budget is not sufficient to improve the timeliness and quality of veterans' health care, renovate the rapidly deteriorating physical plant, replace worn and obsolete equipment, expand geriatric programs or, indeed, accepting any of the numerous tasks remaining to adequately prepare for the future.

Under this budget proposal the VA will, at best, only be able to continue to care for those veterans currently under its charge with no room for improving the quality of that care or preparing to meet the predicted dramatic increase in demand for care by a rapidly aging population. The VA health care system has suffered under flat or decremental budgeting for the past ten years and it is only after the damage that this has occasioned is repaired and additional funding is provided that the VA health care system will be able to prepare for current and future demand.

Question (2)

WHAT DO YOU SUGGEST AS SOURCES OF THE ADDITIONAL $2 BILLION RECOMMENDED IN THE INDEPENDENT BUDGET?

VFW RESPONSE

The Veterans of Foreign Wars working in conjunction with three other veterans service organizations has drafted an Independent Budget for Veterans Affairs which, among numerous other things, delineates a proposal that would generate 1 billion dollars in savings more than the cuts mandated under the Omnibus Budget Reconciliation Act of 1990. It is our intention that these funds would accrue to the Department of Veterans Affairs discretionary account and be utilized to improve the veterans health care system as well as the benefit program and the national cemetery system. We recommend the reallocation of these additional funds within the 302B account as the mechanism for directing these VA savings funds back into the VA system.

The Independent Budget premise for the deficit reduction plan is that VA generated savings exceeding deficit reduction targets for fiscal years 1991 through 1995 should be restored to VA to enable it to improve services to veterans and to make up for 10 years of decremental budgeting within the VA health care system. Excess savings generated in this way do not constitute additional appropriations and their use, therefore, will not affect Budget Authority in a given fiscal year. For the particulars of this deficit reduction plan we would refer you to the text of the Fiscal Year 1992 Independent Budget.

Question (3)

IF YOU WERE TO REFORM THE DIC PROGRAM, WHAT TYPE OF FORMULA WOULD YOU SUGGEST BE USED TO ATTAIN EQUITY?

VFW RESPONSE

While the VFW concurs that DIC reform is very much in order the voting delegates to our most recent National Convention have not formally articulated our position with respect to this issue in the form of a current resolution. The national organization, therefore, is not empowered to recommend or advocate any particular change in the DIC formula. It is however, our contention that while the DIC rates for junior enlisted and officer personnel need to be increased-- these are individuals most often with young families with very limited capital assets who are most in need of assistance--we would urge great caution in amending the DIC formula so that it remain equitable to all concerned parties.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

March 15, 1991

Honorable Bob Stump
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Representative Stump:

Thank you for your interest in the Independent Budget. The Veterans Service Organization sponsoring the document appreciated the opportunity to be heard as a panel on February 27, 1991.

We have done our best to respond to the questions you posed to us regarding this testimony. We hope that these responses will be useful to you in developing your recommendations for an equitable budget for veterans.

The Independent Budget panel welcomes the opportunity to address any further questions you may have about the Independent Budget's formulation or content. We look forward to working with you and your staff in the near future.

Thank you for your consideration of what we feel is a reasonable plan for the Department of Veterans Affairs in FY 1992.

Sincerely,

Richard B. Fuller
National Legislative Director

Attachment

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300 Fax (202) 785-4452

Responses to Post-Hearing Questions Submitted to PVA by Honorable Bob Stump

Questions:

There are approximately 2 billion dollars more in your proposed budget than in the administration's proposal. Given the spending caps we are facing, the extra 2 billion may not be achievable.

1. Would you spend the $13.7 billion for health care differently than the administration?

2. What do you suggest as sources of the additional $2 billion recommended in the *Independent Budget*?

PVA Response:

1. VA has no alternative but to use the $13.7 billion Medical Care budget allowed by the Administration to attempt to continue current programs. When the costs of unavoidable pay raises and inflation are taken into account, the Administration's budget leaves no room for decision. VA cannot meaningfully set priorities among its urgent demands to address unmet need, improve the timeliness and quality of service, replace obsolete equipment, and expand geriatric programs.

   VA can meet none of these demands with the available resources. VA can only continue to care for as many veterans as it can, as best it can. Improvements will have to wait until there is money to repair the damage of past budget shortfalls and to allow VA to adjust to the changing economies of medicine and the growing needs of aging veterans.

2. PVA and the other veterans service organizations cooperating on the *Independent Budget* have described a proposal that would generate one-billion dollars more savings than would the entitlement cuts mandated by the Omnibus Budget Reconciliation Act of 1990. These savings should be transferred to the VA discretionary account and spent to improve VA benefits services, VA medical care, and the National Cemetery System. Additional funds should come from reallocation within the 302B account.

   The VSOs' deficit reduction plan builds on OBRA provisions or and on OBRA's Title XVIII--The Budget Enforcement Act of 1990 and other legislative precedents. Although some elements of the plan are not incorporated specifically within enacted legislation--for example, crediting savings from the attrition of the compensation and pensions rolls-- we believe there is ample supporting authority for our position.

   OBRA's goal is to reduce the deficit by maintaining spending at set limits. This means that VA's budget authority for FYs 1991-1995 has been set by law and appropriations in those set amounts should be forthcoming. The premise of the *Independent Budget's* deficit reduction plan is that internally-generated savings exceeding the deficit reduction targets, incorporated both within OBRA and the budget authority allocations for FYs 1991-1995, can and should be made available to VA. These excess savings are not additional appropriations and their use therefore will have no effect on the FYs 1991-1995 budget authority allocations set in the Concurrent Budget Resolution. The sources of savings in the VSO's alternative deficit reduction plan are shown in the table below.

The VSO Deficit Reduction Plan
(dollars in millions)

	Savings FY 1991	FYs 1991-1995
PENSIONS		
a. Outlays less than inflation	138	822
b. Decrease in outlays from FY 1990 base	40	200
IRS Income Match	90	933
COMPENSATION		
a. Outlays less than inflation	480	1,389
b. COLA (deferred payment)	49	49
MEDICAL CARE COST RECOVERY	113	826
SSN DEATH VERIFICATION	4	47
HOME LOAN GUARANTY		
a. Decrease defaults/foreclosures	100	1,000
b. Include resale losses in net value	80	445
TOTALS	1,094	5,711

Furthermore, substantial cost-savings which could be achieved by VHSRA by taking the steps recommended by the VSOs in the *Independent Budget*. These suggestions include:

- VA should locate high-technology diagnostic and therapeutic programs only where they can meet workload volume standards. Where opportune, the Department should participate in sharing arrangements to ensure efficient use of this equipment.
- In the course of VAMC mission review and reassignment, VA should confine tertiary medical care to large teaching hospitals that serve as referral centers to satellite VA facilities.
- In the course of VAMC mission review, VA should eliminate any services duplicated in proximate sites.
- VA should allow additional programs or activities beyond the assigned VAMC mission only after central review and approval of proposed programs' consistency with overall VA strategic and operating plans.
- Activating a Geriatric Evaluation and Management Program in each VA medical center would save significant resources by enabling timely, comprehensive assessment of elderly patients' medical care requirements.
- VA should make every effort to shift, wherever possible and appropriate, inpatient acute care to more efficient outpatient delivery settings.
- VA should reduce acute care patient length of stay in VA hospital beds wherever possible, to come closer to private sector hospital stays. There are, however, valid reasons why VA and private community lengths of hospital stay cannot be entirely comparable.
- VA should always favor converting excess VA hospital beds to nursing home beds over constructing new nursing homes.
- Congress should correct Category A entitlement so that VA can utilize more efficient outpatient modalities of treatment. Currently, some Category A patients are

hospitalized for procedures simply because ambulatory care is not authorized for them.

- VA should shift many veterans currently in long-term care institutions to less expensive sustaining care in such non-institutional programs as community residential care, hospital-based home care and adult day care centers.
- All CHAMPVA health care should shift from the private medical sector into VA medical centers.

Although we cannot determine amounts which would be saved by adopting these practices, the VSOs believe that savings would be considerable. The government's obligation to veterans is such that even if savings cannot be achieved through other channels, adjustments should be made in the 302b account to accommodate workloads determined by the *Independent Budget*.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

March 25, 1991

The Honorable Bob Stump
Ranking Minority Member
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington D.C. 20515-6335

Dear Congressman Stump:

On behalf of the members of Paralyzed Veterans of America, I wish to thank you for soliciting our views regarding the potential reform of VA's Dependency and Indemnity Compensation (DIC) program. For many of the dependents and survivors of our service-connected members, DIC represents the single most important benefit program administered by the Department of Veterans Affairs. Our concern for equitable DIC reform goes back many years and has always been one of our highest legislative priorities. We, therefore, greatly appreciate your interest in the program and in finding an equitable solution to the complexities surrounding this important issue.

At the outset, PVA is in total agreement with the Administration concerning the unfairness of the present formula upon which DIC benefits are based. Certainly, we agree that DIC benefits should not be reflective of an individual's military pay grade. In our opinion, there is simply no correlation between one's service-connected death, the rate at which one was paid while on active duty, and the subsequent rate of DIC. We are pleased that the Administration and most other interested parties are focusing on alternative criteria for determining the DIC formula.

Having said that, we must, emphatically, state that we strongly oppose the "flat rate" alternative suggested by the Administration in its budget recommendations for fiscal year 1992. The "flat rate" concept continues to deny an equitable death benefit for the survivors of catastrophically disabled veterans.

As stated by the Department of Veterans Affairs, the major objective of the DIC program is to provide benefits to the spouses and dependents of individuals whose deaths were due to service, or as a result of service-connected disabilities, to make up for the loss of family income. PVA strongly believes that an equitable DIC formula must recognize the veteran's degree of disability and the loss of income experienced by the spouse at the time of the veteran's death.

The loss of family income for the spouse of a severely disabled service-connected veteran is significant - over eighty percent for those with no other outside income. For example, immediately at time of death, the family income of a surviving spouse of a paralyzed veteran will drop from $4,731 to $701 per month under the "flat rate" concept. Although part of this reduction is due to the fact that the "aid and attendance" portion of the total compensation award is no longer necessary, the total loss of income, despite on-going expenses and the reasonable desire to maintain a stable lifestyle, causes true financial hardship for the vast majority of those survivors who provided care for their service-disabled spouses for so many years. Simply by virtue of the eighty percent reduction in benefits, financial hardship becomes a genuine reality.

Building an estate when VA benefits represent the only source of income is truly a difficult task for severely disabled individuals. Only 9% of our members are employed on a full-time basis and would be in any position to set aside a portion of earned income for the purpose of building an estate. Although PVA is grateful for compensation benefits which are meant to place disabled veterans on an even playing field with their non-disabled counterparts, the whole financial picture for most severely disabled veterans, including the inability to purchase commercial life insurance at reasonable premium rates, is simply not conducive to the accumulation of wealth. For severely disabled veterans, compensation benefits represent "working income," not income for discretionary use.

Further, with the exception of deaths which occur on active duty or within five years following discharge, this loss in family income is not offset by life insurance programs such as Servicemen's Group Life Insurance (SGLI) or Veterans Group Life Insurance. Rather, these spouses can only anticipate Service-Disabled Veterans Insurance (SDVI) proceeds with a maximum face value of $10,000.

Although we understand the financial needs of younger spouses with young children, we urge you to consider the older spouse of a severely disabled veteran who cannot, realistically, be expected to return to school or to begin a career. Although often willing to seek employment at time of the veteran's death, the surviving spouse generally does not have marketable skills due to the constant care provided over the years to the severely disabled veteran - care, we must point out, that often resulted in enormous savings to the government in situations where veterans would have otherwise required extensive institutional medical care. Coupled with the difficulties associated with building an estate, the surviving spouse of a severely disabled veteran is clearly at a disadvantage when the veteran's compensation benefits are terminated.

In summary, PVA believes reform in the DIC program must address the following issues:

- Degree and duration of veteran's service-connected disabilities
- Loss of family income
- Length of marriage

We believe this can be accomplished through an enhanced DIC program or through an enhanced "survivors' death benefit package" to include improvements in the SDVI program and Veterans' Mortgage Life Insurance. In the case of SDVI, legislation to provide the availability of supplemental life insurance for which disabled service-connected veterans could elect to pay standard premium rates would go a long way towards providing equitable relief to DIC survivors.

Finally, we firmly believe that the inequities associated with current survivors' benefits programs could be greatly alleviated if Congress were to focus on the adequacy of compensation rates - especially, in the rates provided under section 314, paragraphs (k) through (s), title 38 USC. For severely disabled veterans in receipt of compensation benefits set forth in paragraphs (r)(1) and (r)(2), for example, very little compensation remains to be set aside for the care of a surviving spouse. Household and medical care expenses, representing necessary services far beyond that which can be reasonably provided by a spouse, quickly erode the potential for estate savings. In addition to the issue of death benefits, therefore, we strongly encourage the Congress to look closely at the adequacy of aid and attendance allowances.

PVA looks forward to working with you to find answers to these issues. Again, thank you for your interest in this matter and please call on us if we can be of any assistance.

Sincerely,

Richard B. Fuller
National Legislative Director